kidscount in Nebraska

2005 REPORT

A Publication of Voices for Children in Nebraska

voices for children IN NEBRASKA

kids count

kidscount

2005

Kids Count is a national and state-by-state effort sponsored by the Annie E. Casey Foundation to track the status of children in the United States utilizing the best available data. Key indicators measure the education, social, economic and physical well-being of children.

Kids Count in Nebraska is a children's data and policy project of Voices for Children in Nebraska. An important component of this project is the Technical Team of advisors. The Kids Count Technical Team is comprised of data representatives from the numerous agencies in Nebraska which maintain important information about child well-being. This team not only provides us with information from their databases but advises us on the positioning of their data in relation to other fields of data as well. We could not produce this report without their interest and cooperation and the support of their agencies. Kids Count in Nebraska, sponsored by The Annie E. Casey Foundation, began in 1993. This is the project's thirteenth report. Additional funding for this report comes from Share Our Strength (S.O.S.).

Kids Count photographs featured are all Nebraska children. Several issues and programs may be discussed in a particular section. Children featured in each section represent elements of that section but may not be directly involved with all programs or issues discussed therein.

Additional copies of the 2005 **Kids Count** in Nebraska report as well as 1993, 1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004 reports, are available for $10 from:

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Special thanks to:
Early Head Start, Omaha, Neb.
Liberty Elementary School, Omaha, Neb.
Child Saving Institute, Omaha, Neb.
The Robert Wood Johnson Foundation
Douglas County Juvenile Drug Treatment Court

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Commentary 2005

The sections that follow in this report describe the current state of child well-being in Nebraska and trends that have occurred over the past 5-10 years. Topics will include children who participate in Head Start, who are abused, who are products of single families, and many other circumstances affecting Nebraska's children. For some programs and areas of concern, quantitative data is readily available. Other concerns are expressed on individual levels but are more difficult to document or measure. Use of methamphetamine is one such area. There is data identifying arrests and criminal activities related to meth use. There was not data enabling us to measure the relationship between meth use and child abuse or neglect.

It appears that meth use has the potential to affect children from every section of the *Kids Count Report.* Throughout 2004, child advocates, media outlets, the Nebraska Legislature and police departments have all worked to identify the problems associated with the use of meth by parents and guardians, pinpoint its affects on children, and determine solutions to help children who find themselves in a situation where they are affected by meth. Media coverage exposed deaths that appeared to be a result of Sudden Infant Death Syndrome (SIDS) that were ultimately connected to meth use and sleeping locations. An extreme case found a meth addicted mother sleeping in a playpen, allegedly causing suffocation of her infant.

Voices for Children in Nebraska and the Douglas County Attorney's Office each had a desire to better understand the prevalence of meth use in adjudicated abuse and neglect cases. Following a review of 94 cases during the Summer of 2005, Voices for Children in Nebraska released summarizing findings. Of the 94 cases read, 34 cases, or 36%, included meth in some form. While the cases were reviewed from "child abuse and neglect" files, the effect meth has on children's lives is more encompassing. For example, 8 of the 34 cases involved truancy. Typically, mom or dad were too high on meth to make sure the kids were going to school or older siblings had to stay home and take care of younger siblings while mom or dad were in the "crash phase" of a meth high where they would sleep for several days. Also, the neglect that occurred was not always directly related to a child's care, but others indirectly, such as leaving the child in an unsafe environment. Social workers described incidents of cockroaches covering floors and walls, inoperable bathrooms and no food in a kitchen.

Children exposed to meth over time, from either meth manufacturing in the home, or through exposure when mom or dad smokes it, will face serious challenges to their health both mentally and physically. Such exposure can lead to the following problems:

- Physical:
  Similar to Parkinson's disease
  Severe movement disorder
  Damage to the brain, liver, kidneys, lungs, eyes and teeth
  Hyperactivity, decreased appetite, increased respiration

- Mental and Emotional:
  Insomnia, anxiety, paranoia
  Low self-esteem, poor social skills
  Increased likelihood of delinquency, teen pregnancy, school absenteeism, drop out, peer isolation

Moms have admitted to using meth as a weight-loss or weight control drug, however, they probably do not realize that when they're on meth, they're not going to be able to be as functional as a parent. In the Douglas County report, in 34 cases, 74 children were affected. These children are at risk for bodily harm or death because their parents are not fully aware of what's happening. The foster care system is seeing an increase of children due to parental use of meth. What's more, of the 34 cases in Douglas County where meth was present, 13 cases included mothers who gave birth to a baby who had meth in their system. This means the mother ingested meth 1-3 days before the birth of their child and was directly exposing their infant to the harmful side effects of meth listed above.

The Nebraska Legislature, during the 2005 legislative session, attempted to combat the meth problem through the four following bills.

LB 117 was the only one of the four bills to be passed by the Nebraska legislature. This bill forces pills containing pseudoephedrine (such as drugs for the "common cold") to be sold from behind a counter or in a locked cabinet. It also requires a buyer to be 18 years old with a government issued ID and sales to be limited to 48 doses in a 24-hour period.

LB 481 sought to make drugs containing pseudoephedrine (common cold medication) only available to a person with a prescription from a doctor. Again, the purpose was to make it more difficult to make meth since pseudoephedrine is used in making meth, and manufacturers typically make meth by using cold medicine. This bill was not passed by the Nebraska legislature.

LB 148 would have made it a felony child abuse offense to place a child near the manufacturing or production of meth. While this bill did not pass in Nebraska, similar laws have been enacted in the following states: Arizona, Colorado, Idaho, Illinois, Missouri, Montana, New Mexico, Oregon, Utah and Washington. The purpose of such a law would be/is to avoid the primary risks associated with meth production (risk of long term effects, bodily harm or death due to explosion or fire started from the production method). It is also seen as a way to deter meth production to ideally lower the amount of meth available.

LB 149 required the disclosure of past meth production in homes to buyers and renters. Due to meth's highly toxic nature, and the fact that when meth is produced in a home it literally saturates everything, disclosure would at least put a home buyer or renter on alert that the home needs to be thoroughly cleaned. The legislature did not pass this bill.

While three of the four bills did not pass, the legislature did enact Legislative Resolution 69; an interim study to investigate and provide recommendations to address public health hazards created by meth.

Steps have been taken to combat meth and its harmful effects on children. The following are recommendations based on the analysis and recommendations of task forces from around the country and the Department of Justice:

- Enforce and require the procedures implemented by CHEM-L to combine legal, social and medical professional resources to break the cycle of child endangerment.

  CHEM-L is a program initiated by the Center on Children, Families, and the Law through the University of Nebraska, Lincoln, a Medical Working Group, and High Intensity Drug Trafficking Area (HIDTA). CHEM-L serves as a guide, or protocol, for Nebraska police officers, Health and Human Services case workers and any medical personnel who come in contact with children who are removed from homes where meth is manufactured.

  CHEM-L protocol includes a holistic record of the child's contact with meth: a child's history of exposure to meth is documented, the child visits a doctor and dentist and provides vital information regarding the child's contact with meth to foster care providers to ensure a greater understanding of the child's needs.

- Introduce higher standards for cleaning meth houses before they may be sold or rented (Oregon and Washington statutes).

- Use meth as a "very dangerous" factor for a child's well-being in determining parental custody.

- Foster Care Problem:

  Taking children away from parents who use meth and placing them in foster care is a complex issue as it is placing children in an already overwhelmed foster care system. Therefore, a better solution may be treatment and Drug Courts.

  Douglas County saves taxpayers $3.4 million a year by using drug courts. This report stated that there are fewer "up-front" costs and lower recidivism rates, the money saved could be used to fund and support the foster homes already in place and for recruitment of new foster homes. *(NADCP news, Fall 2004)*

  In the 34 cases involving meth, parents always tried and used other drugs first, before using meth. Getting people off of drugs through rehab the first time they are caught may help prevent meth-related child maltreatment.

- Enact a bill making it a Class III felony for exposing children to meth labs similar to LB 148 which the Legislature left in the General File during the 2005 legislative session.

  Wyoming made it a crime for children to come into any kind of contact with any amount of meth. Parents or guardians are fined $5,000 or 5 years in prison. (www.craigdailypress.com/section/darkcrystal/storypr/12082)

- Establish and fund residential treatment facilities where parents go through rehab and children may stay to be tested and/or treated for their exposure to meth. Family therapy may be used to help keep the family intact.

  The National Institute of Justice (US Department of Justice) wrote a report in April 2002, *"Research in Brief on Nebraska"* regarding meth use in the state. They found that some arrestees felt they needed treatment to get off meth, but NO arrestees were receiving treatment at the time of their interview.

  Meth abusers have the same success rate as heroin and crack/cocaine treatment. There needs to be cognitive/behavioral intervention to help modify the patients' thinking, expectations and behaviors. (www.prevlink.org/clearinghouse/catalog/drugs/meth/methbro.pdf)

- Rely on extended family members to care for the child while parents go to rehab.

- Increase the penalty for those who disobey LB 117 (restricted sale of pseudoephedrine) and hold businesses responsible for carrying out proper procedure.

Nebraska must make parents think before they manufacture meth or use the drug. Media outlets have been doing their part by keeping meth and its negative effects in the news, but Nebraska must take more preventative measures to keep our children safe. First, prevention of drug use and rehab is the first step in lowering incidences of child maltreatment due to meth by getting people off of drugs before they start using meth. Second, Nebraska needs to make meth harder to manufacture. The Nebraska legislature has taken steps to accomplish this by passing LB 117; however, this bill's enforcement will be the key to its success. Third, by adding and implementing CHEM-L into everyday practices and including other of the above recommendations, Nebraska will be more effective in their approach to dealing with children of meth cases. Meth use is not unique to Nebraska, but that does not mean we have to be susceptible to meth's harms. Nebraska can help its children stay safe.

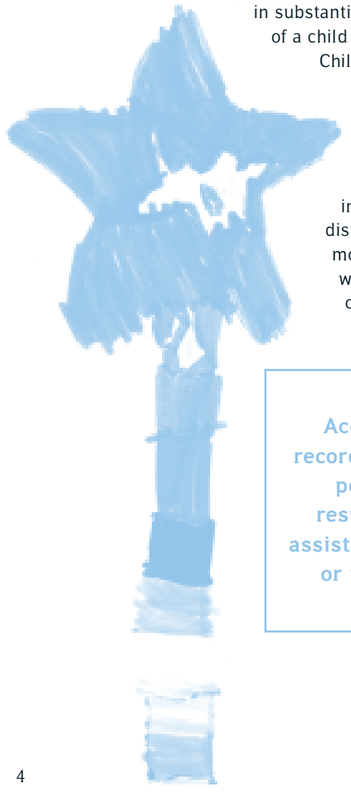
Child Abuse & Neglect
Domestic Violence

The maltreatment of children affects those individual children, their families, their communities and our society. Violence, whether observed or directly felt by a child, can disrupt growth and development, lower self-esteem, perpetuate a cycle of violence and cause or exacerbate mental health problems. The result is often academic underachievement, violent behaviors, substance use and low productivity as adults.

Investigated and Substantiated Cases

The Department of Health and Human Services (HHS) received 24,111 calls made to the Child Abuse/Neglect Hotline in 2004. Of those calls, 20,568 were for alleged child abuse and neglect, an increase over the 16,246 calls received in 2003. The hotline averages nearly 66 calls a day. Of the 20,568 child abuse and neglect calls received, 13,291 were investigated resulting in 3,336 substantiations involving 5,008 children. This is an average of 36 new investigations each day, 64 child abuse and neglect substantiations involving nearly 96 children per week.

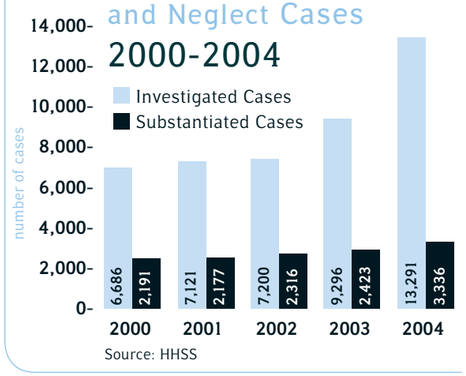
In 1998, HHS changed the way in which child abuse and neglect data was collected. In 2004, data extraction formulas were improved, resulting in changes to calendar year 1999-2002 data. This is the most up to date data available regarding the number of child abuse and neglect reports and investigations. In addition to the updated statewide data, information is now available pertaining to the six individual HHS Service Areas and individual counties.



Data shows substantiated cases are more likely to involve young children. In 2004, 64.4% of the children involved in substantiated cases were ages 0-8. The average age of a child in a substantiated case was 7 years old. Children ages 0-3 represented 1,632 or 33.4% of the children involved in substantiated cases. Children age 2 or under accounted for 1,221 almost 24.9%, of the victims. Older children are not less likely to be abused but, instead, children who are younger often display stronger evidence of abuse, making it more likely to be reported. In 2004, there were 2,504 female children and 2,392 male children involved in substantiated cases.

According to hospital discharge records, males are the most probable perpetrator of physical abuse resulting in the need for medical assistance and are usually the spouse or partner of the child's mother.

Statewide Child Abuse and Neglect Cases
2000-2004



Source: HHSS

It's the Law!

The state requires all citizens who suspect or have witnessed child abuse or neglect to report the incident to their local law enforcement agencies or to Child Protective Services (CPS).

Only 1% of child abuse reports to HHS or law enforcement come from the children themselves. Children often have strong loyalties to their parent(s) and/or the perpetrator and therefore are not likely to report their own, or their siblings', abuse or neglect. These children may fear the consequences for themselves, the perpetrator and/or their parent(s). There is also a strong possibility the perpetrator has threatened more serious abuse if they tell. Children may be more likely to tell a trusted adult such as a teacher, care provider or family member if they believe that person will help the family.

Types of Abuse

Neglect, physical abuse and sexual abuse are the three main classifications that fall under the umbrella of child abuse. Because children may experience more than one form of abuse, HHS records all types of abuse that apply to each child individually. Over the years, neglect has been found to be the most commonly substantiated form of child maltreatment. If a child has not been provided for emotionally, physically and/or medically, it is considered neglect. Infants and children labeled as "failure to thrive" are often the result of neglect.

Type of Allegation (abuse)	Female	Male	Total
Physical Abuse	351	388	739
Emotional Abuse	121	110	231
Sexual Abuse	298	56	354
Emotional Neglect	107	103	210
Physical Neglect	1,625	1,735	3,460
Medical Neglect of Handicapped Infant	2	0	2
TOTALS	**2,504**	**2,392**	**4,996**

Source: HHS **Totals may vary due to rounding*

Child Abuse Fatalities in 2004

Unfortunately, the 2004 child death statistics were not available in time to be included in this report. However, according to Vital Statistics, in 2003, 14 Nebraska children died as a result of child abuse and/or homicide.

In 1993, the Nebraska State Legislature mandated formation of a Child Death Review Team to review all child deaths. The first report in several years was published, covering the years in 2004. We look forward to more regularly published Child Death Review Team reports to provide both a more accurate record of the number of children who have died due to the tragedy of child abuse and begin to identify strategies to prevent these tragedies.

Domestic Violence/ Sexual Assault Programs

In Nebraska, there are 22 community-based domestic violence/ sexual assault programs, as well as four tribal programs serving the Ponca, Winnebago, Omaha, and Santee Sioux nations. These programs offer a range of services for both adults and children who are victims of domestic and sexual violence, including: 24 hour crisis lines, emergency food, shelter, and sundries; transportation; medical advocacy and referrals; legal referrals and assistance with protection orders; and ongoing support and information.

During the fiscal year 2003-2004, the 22 community based programs served 9,858 people, including 2,399 children and youth. Over two thousand people (2,329) received shelter, including 1,329 children. A total of 49,493 shelter beds were provided, with 29,200 provided to children, and 82,048 meals were provided, with 76,710 to children. The programs also provided 81,005 hours of support and assistance to victims of domestic and sexual violence of all ages.

Of the people who provided demographic information, 5,369 children were reported as living in the home, 372 were reported as having been physically harmed, 91 were suspected of being victims of child sexual abuse and 3,324 witnessed the perpetrator's use of violence.

Domestic violence and sexual assault have no boundaries – they occur in all socio-economic levels, religions, cultures and communities. This violence also occurs in both adult and teen relationships. A 1994 survey[1] of over 1,200 Nebraska teens found that 49% of the teens had experienced one or more forms of abuse in a dating relationship and 54% of those teens suffered physical abuse (e.g., hit, punched, slapped, shoved, kicked, choked, burned or forced to have sex). Additionally, 55% of teens knew someone who had been hurt in a dating relationship.

Although dating violence is prevalent, the study found that 25% of teens do not tell anyone about the abuse.[2] Of those who do seek help, 66% tell a friend and 26% tell a parent.[3] Nebraska's Network of Domestic Violence Sexual Assault Programs seek to raise awareness of dating violence and the resources available to support the victim and hold the perpetrator accountable. Many programs work closely with local schools to implement presentations on dating violence, rape, sexual harassment and healthy relationships. During the 2003-2004 fiscal year, the programs reached 32,966 middle and high school students on these topics.[4]

policy box

A CHILD CENTERED APPROACH TO CHILD ABUSE

In 2003, the Governor's Children's Task Force recommended facilitating and enhancing the exchange of information between law enforcement and Child Protection Services (CPS), and promoting a multi-disciplinary approach to the investigation of child maltreatment reports by strengthening the 1,184 teams through funding for coordination, training and operating expenses for these teams. The coordinators for these teams are housed in the Child Advocacy Centers across the state. The funding for these positions has been a great first step in focusing on the needs of children in Nebraska.

The purpose of Child Advocacy Centers (CACs) is to provide a comprehensive, culturally competent, multidisciplinary team response to allegations of child abuse in a dedicated, child-friendly setting.

The multidisciplinary approach to investigations can lead to a more effective, long-term positive outcome for children and families affected by abuse. By bringing all "players" to the table, the response to cases can be helpful in improving communication between all responders of child abuse cases.

Recognizing of the importance of the Child Advocacy Center model by the Nebraska State Legislature has helped these centers also become integral to the shaping of public policy initiatives that will influence the lives of Nebraska children and families. In 2005, $375,000 in funding was provided to the centers by the legislature to help fund and sustain the programs within the agencies.

Source: Project Harmony Protection Center, Omaha, Neb.

Early Childhood Care & Education

Early childhood is the term used to describe children from birth to age eight. During this critical period, children will grow and learn more than they will at any other time in their lives. In Nebraska, 73% of working mothers have children under the age of six. Whether young children are receiving care at home, in centers or preschools, or from family child care home providers, they require a high quality, nurturing environment in order to make the most of this developmental stage. Young children who receive quality care may benefit cognitively, socially and emotionally, thus increasing their chances of achieving productivity in adulthood from which we all will benefit.

Early Childhood Development Programs in Nebraska

Head Start and Early Head Start

Head Start and Early Head Start programs are federal funded programs. The programs provide comprehensive services in child development, health and wellness, nutrition and social services to support low-income families who have infants, toddlers and preschool children. Early Head Start also serves pregnant women preparing for the birth of their child. The four cornerstones of Head Start include: child development, family development, staff development and community development. Children participate in various program formats including: center-based, home-based or a combination to focus on the cognitive, social and emotional development in preparation for the transition to school. Research shows that Head Start children perform better in school and eventually in employment than those children of similar circumstances who did not participate in Head Start.

Early childhood brain research provided a catalyst to funding Early Head Start programs within the last decade. Research concluded that developmentally appropriate experiences contribute to the healthy development of an infant's brain and make a significant difference in whether a child may reach his or her full potential. Head Start and Early Head Start assist parents in helping their children reach their full potential through parenting education and support, mentoring, volunteering and employment opportunities and collaborations with other quality early childhood programs and community services.

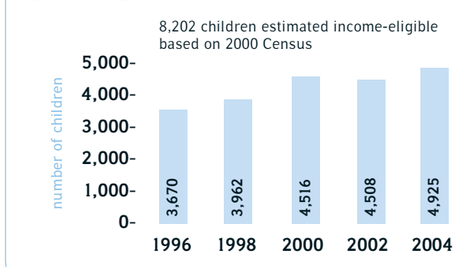
During the 2003-2004 program year, 15 Head Start and 8 Early Head Start programs were operated by 21 grantees including: two delegate agencies, three American Indian programs and one Migrant program. These programs served children in 71 of Nebraska's 93 counties.

Head Start and Early Head Start services were offered in a variety of settings in the state. Head Start or Early Head Start operated 251 classes. An additional 44 classes serving children in Head Start or Early Head Start were operated through child care center partnerships. Also, two family child care homes provided Head Start/Early Head Start services. Finally, 121 socialization groups provided services to the 787 children served by home-based programs.

According to the Head Start Program Information Report for the 2003-2004 program year, Head Start/Early Head Start programs in Nebraska served 6,428 children birth through age five and 152 pregnant women. Forty-two of the women were under 18 years of age. Of the 6,428 children, approximately 3,200 needed child care for full days and/or for the entire calendar year because their parents were working or were in job training programs. More than 1,400 children in Head Start/Early Head Start programs spoke a language other than English and 836 children had a disability.

How many of Nebraska's 8,202 eligible 3- and 4-year-old children were enrolled in Head Start Programs?

1996-2004



Source: Nebraska Department of Education

State Grant-Funded Early Childhood Programs

Since 1992, Early Childhood Projects served young children and their parents in 10 Nebraska communities. In 2001, in response to the Governor's identification of early childhood as a state priority, the legislature appropriated additional funds to expand the number of programs. In 2003-2004, 28 school districts or Educational Service Units (ESUs) received grants to provide child development programs throughout communities across Nebraska. The grants ranged from $30,000 to $50,000 per classroom. Grantees were required to collaborate with existing local providers, including Head Start. The collaborative groups combined the grant funds with existing resources to operate integrated early childhood programs which improved access to services for young children in those communities. A majority of the 1,357 children served were from low-income families, as was reflected by the 66% of children who were eligible for free/reduced lunch. The grant-funded programs predominately served preschool age children. In fact, 87% of the children were three or four years of age. Many children receiving services through the early childhood education grant-funded programs had a home language other than English (32%). Additionally, 16% of the children had parents who were less than 18 years of age or were not high school graduates.

Even Start Family Literacy Program

Even Start is a program of the US Department of Education administered through the Nebraska Department of Education Office of Early Childhood. The Even Start Family Literacy Program is intended to help break the cycle of poverty and illiteracy and improve the educational opportunity of low income families by integrating intensive early childhood education, adult literacy or adult basic education including support for English language learners and parenting education.

During the 2003-2004 grant year, a total of eight Even Start programs were funded across Nebraska. Eligible participants in Even Start programs are parents who qualify for participation in an adult education program and their children, birth through age 7. To be eligible, at least one parent and one or more eligible children must participate together in all components of the Even Start project. Program components include early childhood education/development, parenting and adult education.

Nebraska Even Start programs served 349 families, including 367 adults and 479 children. More than half of the parents served were participating as English language learners (61%). Sixty-seven percent of the families were at or below the federal poverty line.

Early Childhood Special Education and Early Intervention Programs

In Nebraska, school districts are responsible for providing special education and related services to all eligible children in their district, from birth to age 21, who have been verified with a disability. In order for a child to be eligible for special education and related services, the school district must evaluate the child through a multidisciplinary team process (MDT) to determine the educational and developmental abilities and needs of the child. Once the evaluation and assessment for the child has been completed, an Individualized Family Service Plan (for children from birth to age three) or an Individualized Education Program (for children ages 3-21) must be developed for the child. A services coordinator with the Early Development Network is available to assist families with children from birth to age three who have disabilities. In 2004, there were 4,114 children from birth to age five receiving early childhood special education services in Nebraska.

Services for young children with disabilities, birth to age five, are required to be provided in natural environments for children birth to age three, and in inclusive environments for children ages 3 to 5. The terms "natural" and "inclusive" environments are defined as settings that would be natural or normal for the child if he/she did not have a disability. To the greatest extent possible, the early education experience is to be provided for children in partnership with community preschools, child care centers, Head Start programs and other community settings.

Child Care Facilities and Subsidies

In Nebraska, a child care provider or facility providing care for four or more children from more than one family must be licensed by Nebraska Health and Human Services Systems (HHSS). Nebraska continued to lose licensed child care facilities in 2004, with a decrease of 124 facilities leaving 3,917 facilities. The 2000 Census calculated 117,048 children under age five in Nebraska. The vast majority will require child care outside the household at some point in their young lives. The lack of quality and licensed child care in Nebraska often results in long waiting lists and families' use of unlicensed care.

In 2004, families who had previously received Aid to Dependent Children (ADC) with income at or below 185% of the federal poverty level (see Economic Well-being section of this report), could utilize child care subsidies. Families who had not received ADC were eligible only if their income was below 120% of the federal poverty level. Throughout 2004, HHSS subsidized the child care of 27,824 unduplicated children, a decrease from 2003 of more than 670 unduplicated children. The monthly average was 14,208 children. With an average annual cost of $1,692 per child, $47,488,619 federal and state dollars were used for child care subsidies in Nebraska. Subsidies are usually paid directly to the providers. While not all children receive subsidy for 12 months, the average subsidy cost per child paid by Health and Human Services during SFY2004 was approximately $278 per month, more than $1,692 a year. The rates established to pay for child care subsidy for preschool and school age children range between $13 and $21 per day. For in-home care, where the child care provider comes to the home of the child, HHSS uses a basic rate of $5.15 per hour.

impact box

EARLY CHILDHOOD CARE IN NEBRASKA

In Nebraska, the average child care provider/teacher:

- Has a high school diploma with some additional training hours
- Earns an average of $7.07 an hour

The Midwest Child Care Study found in Nebraska:

- 18% of child care was ranked as poor
- 44% ranked as minimal
- 37% ranked as good

A body of research has shown that the early years are the most important in the development of the child. A safe, caring and learning environment will have a life-long impact on the child.

Additional research has shown the greatest determinant in the quality of early care and education is the education level of the teacher or provider.

Long term information shows that for every $1 invested in child care for low-income children, $7 is saved.

Source: Midwest Research Consortium: "Child Care Characteristics and Quality in Nebraska."

Economic Well-Being

The general definition of economic self-sufficiency is a family who earns enough income to provide for their basic needs without public assistance. Nebraska Appleseed Center for Law in the Public Interest considers the basic needs budget to consist of food, housing, health care, transportation, child care, clothing and miscellaneous such as necessary personal and household expenses. If a family has the economic ability to provide these essentials without public assistance, they are considered self-sufficient. While it is limited, public assistance is available to families who cannot provide these necessities on their own.[1]

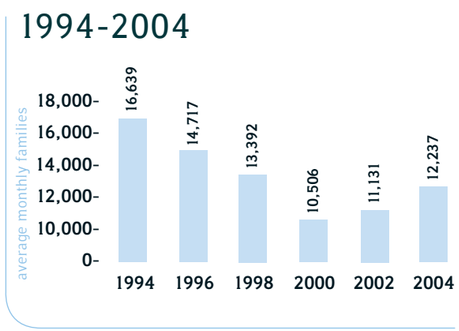
Temporary Assistance to Needy Families (TANF)

Aid to Dependent Children (ADC) remains the title of government "cash assistance" in Nebraska. TANF, as the program is known at the federal level, focuses on non-cash resources and education to foster self-sufficiency among program recipients. Nebraska's Employment First Program was created to assist parents in acquiring and sustaining self-sufficiency within 48 months. Medicaid coverage, child care services and subsidies, and job support are all provided through Employment First; cash assistance may be drawn for 24 of the 48 months.

In Nebraska, ADC was provided to a monthly average of 12,237 families totaling $51,860,777, an average of $353.16 per family in 2004. These families included 22,004 children. Unfortunately, the maximum ADC payment only amounts to approximately 32% of poverty as prescribed by Nebraska law (see the guidelines on page 9). The utilization of ADC decreased steadily since it peaked at 17,239 in 1993, until 4 years ago, when it began to increase again.

Lashell, 7 weeks

How many Nebraska families with children receive ADC?



Source: HHSS

Federal and State Tax Credits for Families

In 2004, a total of $183,856,000 was claimed as Earned Income Tax Credit on 107,430 Nebraska tax returns. The federal government created this tax credit in an effort to assist low and moderate-income working families in retaining more of their earned income. In addition, 159,645 families claimed the Child Tax Credit, receiving $219,882,000 and 51,201 families claimed the Dependent Care Credit, receiving $23,322,000.

At least 13 states have also established a refundable State Earned Income Tax Credits, based on a percentage of the federal credit. This has been an effective assistance program for low-income families. An additional 5 states offer a non-refundable credit only. Nebraska has rejected such legislative proposals. However, Nebraska is one of 12 states that has refundable State Child and Dependent Care Tax Credits, and has received financial support from the National Women's Law Center in Washington, DC to promote these credits to families. Nebraska also offers free tax assistance to families statewide through a collaboration of state and local agencies.

Single Parent Families

Single parent families are less likely to have sufficient support systems and adequate financial resources than two parent families. The lack of these essential resources has been linked with greater parental stress and, therefore, greater occurrence of child abuse. Research shows more than 50% our nation's children will spend all or part of their childhood in a single parent household. Forty-five percent of single parent families headed by a woman and 19% of single parent families headed by a man live in poverty, as compared to only 8% of married couples with children under the age of 18.[2] In 2000, the census showed approximately 20% of Nebraska children lived in a single parent headed household.

Divorce and Child Support

Divorce accounts for 46% of all single parent households.[3] In 2004, 5,942 marriages in Nebraska ended in divorce, involving 6,210 children, slightly more than 2003. Of the 2004 divorces, custody was awarded to mothers 2,187 times, to fathers 367 times and joint custody was awarded 674 times. Child support can be awarded to the custodial parent. Unfortunately, the court awarded child support is not always paid to the custodial parent. A parent can request HHSS assistance if they are not receiving the child support that they are owed. HHSS responded to 98,992 of these cases as of September 2004 and collected $11,062,493 on behalf of children who are dependent on Temporary Assistance to Needy Families (TANF). On behalf of children whose parents were also owed child support but were not receiving TANF, $150,317,090 was collected.

2004 Federal Poverty Guidelines (at 100% of poverty)

Size of Family Unit	Gross Annual Income
2	$12,490
3	$15,670
4	$18,850
5	$22,030
6	$25,210

Source: HHSS
Note: The 2000 census estimates that 12% of all Nebraska children and 14% of Nebraska children under 5 live in poverty.

Homeless Assistance Programs

The Nebraska Homeless Assistance Program (NHAP) funds emergency shelters, transitional housing and services for people who are homeless and near homeless across the state. In 2004, agencies funded by NHAP served a total of 38,726 people who were homeless and 41,796 people who were near homeless. Within these served, unaccompanied youth under the age of 18 accounted for 1,286 of the homeless and 974 of the near homeless. Children accompanied by single parents accounted for 5,730 of the homeless, and 12,338 of the near homeless. Children accompanied by two parents accounted for 3,998 of the homeless and 6,029 for the near homeless.

In addition to providing housing and resources, each region's shelters and units sponsor activities for children. For example, the Omaha Area Continuum on Housing and Homelessness sponsors an art project for children in shelters. This group provides the children with art supplies, ranks the drawings, and has an awards dinner for the families of participants. The art is then displayed during Hunger and Homeless week; the week preceding Thanksgiving.

impact box

THE ROLE OF MEDIATION IN DIVORCE AND DOMESTIC VIOLENCE

Mediation is an effective tool that encourages two or more parties to work together through a neutral third party to reach voluntary and consensual agreements on the matters at hand. It is highly effective because it limits the opportunity for conflict while solving problems. When parents are getting a divorce or are determining a custody arrangement, mediation is recognized as a positive tool that encourages each party to speak their point of view while working together to create a parenting plan. Such a plan establishes issues in areas of custody such as visitation, holidays, and who makes decisions regarding the child's well-being. Mediation and the creation of a parenting plan have also emerged as an option to help victims of domestic violence when there are children involved.

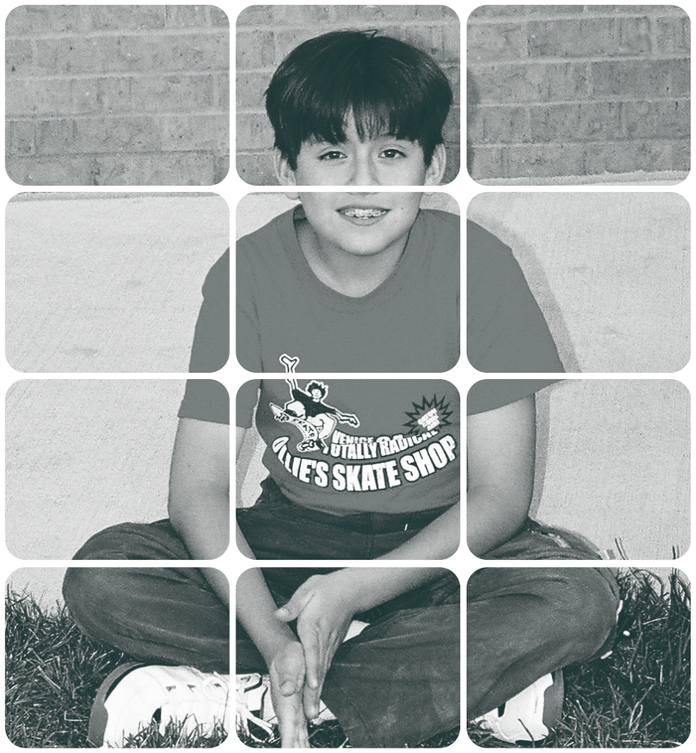
In mediations involving children and domestic violence, mediators must take a child and victim-oriented point of view in order to be aware of power and control issues that may persist. Violence should NEVER be the subject of mediation and mediation should not be used as an alternative to prosecuting someone who has committed a domestic violence. Mediation should also not take place when there is a protection order in effect as it is potentially further endangers the victim's physical security and the victim may not be able to fully participate in the mediation process. Rather, mediation should be used for parents who have a history of domestic violence in determining a parenting plan to limit the child and victim's future risk of violence through specific provisions for pickup and return dates, times, and procedures for a safe exchange. States and court systems have implemented techniques where it is possible for a mediation to be performed over the phone or in separate rooms where a mediator goes back and forth between parties (called "shuttle technique") so that the parties do not have to sit face-to-face, again to avoid conflict and issues of power and control.

Mediators are trained professionals who have learned how to screen parties to balance the issues of power and control that may exist, and also have learned to work with the parties to reach an agreement for child custody that is acceptable to all parties. This is preferable to a court of law where parties are placed in an adversarial position and forced to show the other in the worst possible light. Placing parties with a background of violence in an adversarial position is more likely to create further conflict than a mediation setting where parties are encouraged to work together. Mediation is more likely to prevent future abuse and empowers victims of domestic violence by fostering a system of rules for future interactions between the parties. It allows victims of abuse to see their lives as independent of their abusers. Mediation has been associated with reducing the incidents of abuse, possibly because the process of mediation is less conflict-ridden and conflict-inducing than the traditional lawyer and courtroom settlements. Through promoting cooperation, mediation is a tool to help break the cycle of violence.

Sources: Rene Rimelspach. "Mediating Family Disputes in a World with Domestic Violence: How to Devise a Safe and Effective Court-Connected Mediation Program." www.mediate.com.

Education

Education requires little introduction. It is common knowledge that children who do well in school are more likely to become successful adults. Generally, higher education level is associated with higher income. Higher education is often linked to lower divorce rates, lower crime rates and higher job satisfaction.[1]



Alonzo, 10

High School Graduates

During the 2003-2004 school year, 21,718 Nebraska high school students were awarded diplomas. The 2003-2004 graduation rate was 87.5%. As of 2002-2003, Nebraska adopted the National definition for graduation rate. The definition was developed by the National Center for Education Statistics (NCES). For the past several years, Nebraska published a twelfth grade graduation rate which compares high school diploma recipients to Fall twelfth grade membership for the same year. The NCES definition, instead, attempts to calculate a four-year rate. These are two totally different approaches; one is a one-year retention rate, while the other is a four-year retention rate. For most districts, and for Nebraska as a whole, the graduation rate will be lower under the new definition; however, for a few districts, the graduation rate may increase.

Of the 2003-2004 graduates, approximately 89% were White, Not Hispanic; 4.3% were Black, Not Hispanic; 4.4% were Hispanic; 1.6% were Asian or Pacific Islander and .8% were American Indian/Alaska Native. In addition, 2,208 Nebraskans finished their high school education by passing the GED tests during the 2004 calendar year.

School Dropouts

During the 2003-2004 school year, 2,630 Nebraska students dropped out of school, 1,519 male and 1,111 female. This was 281 fewer dropouts than the previous year. (Dropouts are calculated using grades 7-12.) Minority groups have higher drop out rates than White students. In the 2003-2004 school year, 1.9% of White students dropped out of school. While Hispanic students made up almost 9.2% of Nebraska students, grades K-12, they comprised over 19.6% of the dropouts. Less than 7% of Nebraska students were Black, but constituted nearly 16.8% of the total dropouts.)

Expelled Students

During the 2003-2004 school year, 858 Nebraska students, grades 7-12, were offered alternative education in response to expulsion from customary education. Data based on expulsions by race and gender is no longer collected by the Department of Education.

In general, public school students are provided with an alternative school, class, or educational program upon expulsion. In Nebraska, a student can be expelled from a school but not from the school system, allowing for the student to continue their education in either a formal alternative program or his or her home. Prior to expulsion it is necessary for the student and his/her parents to develop a written plan outlining behavioral and academic expectations in order to be retained in school. Some schools are developing creative and motivational alternative programs to meet the needs of students.

The School Discipline Act of 1994 requires expulsion for students found in intentional possession of a dangerous weapon and/or using intentional force in causing physical injury to another student or school representative.

STATEWIDE EXPULSIONS 1993-1994 THROUGH 2003-2004

1993-1994	209
1994-1995	283
1995-1996	443
1996-1997	615
1997-1998	663
1998-1999	849
1999-2000	824
2000-2001	770
2001-2002	816
2002-2003	857
2003-2004	858

Source: Nebraska Department of Education
Data on expelled students is not longer collected by race or gender.

Special Education

During the 2003-2004 school year, 47,015 Nebraska students from birth to age 21 received special education services. It is important for a child's development and education that the need for special education be identified at an early age. There were 6,010 preschool children, birth to age five, with a verified disability receiving special education services. School districts reported 41,005 students age 6-21 with disabilities.

policy box

TRUANCY

Truancy has been recognized as being detrimental to children's educations, school districts' funding and communities as a whole. Truancy is a typically defined as a student's unexcused absence from school, but each state may have their own definition. According to a nationwide survey, some of the reason children miss school is because of family health or financial issues, substance abuse, students not feeling safe at or on their way to or from school, and lack of self-esteem. The result of truancy is that children are put at risk for: educational failure, social isolation, substance abuse, low self-esteem, unwanted pregnancy, unemployment, violence, and criminal behaviors.

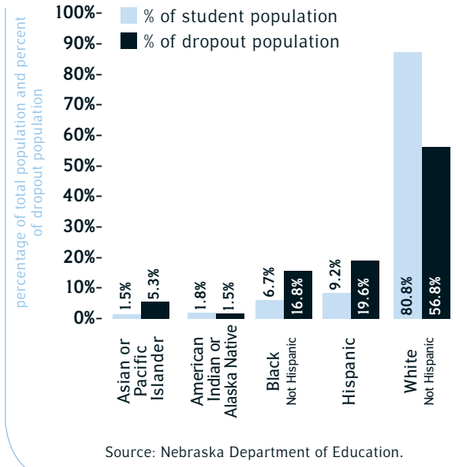
Prevention of truancy requires a combination of people working together. Through family involvement, school support, and the child's effort, truancy can be improved if not solved. Currently, Omaha Public School District (OPS) has initiated a program to address the truancy issue. Under their program, entitled the "Drop-Out and Intervention Plan," when a parent or guardian is concerned about their student missing school, a Student Personnel Assistant is assigned to work with the student and the family to encourage the student's regular attendance. By intervening, the Assistant determines the issues the student has with attending class, and works with the school, family and child to overcome those issues.

Sources: Omaha Public School District, http://mail.ops.org

The Office of Juvenile Justice and Delinquency Prevention, http://ojjdp.ncjrs.org/

Adri, 10, Jake 5

Student Dropout Populations by Race and Ethnicity



Source: Nebraska Department of Education.

Health – Physical & Behavioral

Good health, both physical and behavioral, is an essential element of a productive life. It is no surprise children who receive preventive health care from the time they are in the womb to the time they reach adulthood make healthier adults.

Birth

In 2004, there were a total of 26,324 live births to Nebraska residents. Seven percent, or 1,862, of these births were babies with low birth weight, while the majority were born healthy (see Low Birth Weight section following). Eight and seven-tenths percent (2,290) of babies born in 2004 were to women ages 10-19 which was a slight decrease from the previous year. The number of unwed parents grew slightly in 2004, with 7,954 (30.2%) babies born out of wedlock. Almost 18% were born to mothers who did not receive adequate prenatal care during their first trimester of pregnancy.

Prenatal Care

According to the Centers for Disease Control and Prevention, nearly one third of American women giving birth experience a pregnancy-related complication. Early and appropriate prenatal care can detect potential problems and may prevent serious consequences for both the mother and her baby. The Centers for Disease Control and Prevention recommend starting prenatal care as early as possible, even prior to pregnancy. Prenatal care is measured by the Kotelchuk Index to calculate the adequacy of care.

In Nebraska in 2004, 2,801 births are recorded to mothers who did not receive adequate prenatal care and 4,749 were reported to have intermediate prenatal care. This totals more than 19% of births. Over 72% of White, 69% of Asian, 61% of Black, 51% of American Indian/Alaskan Native and 63% of Hispanic newborns had mothers who received what was considered "adequate or adequate plus" prenatal care.

Unfortunately 2004 statistics were not available in time for this report, however, in 2003, 36 newborns died before their first birthday due to birth defects. Research has shown there is a correlation between the health of the mother prior to conception and birth outcomes. Consuming folic acid prior to and following conception and living a healthy lifestyle will improve the chances of a healthy birth and may reduce the likelihood of birth defects including spina bifida.

Jokereon, 8 months

Infant Mortality

Infant mortality rates are frequently used as an indicator of overall human well-being in a community. Although the United States spends more on health care than any other country, it still has a higher infant mortality rate than 21 other industrialized nations.[1] Again, 2004 statistics were not available in time for this report, but in 2003, the Nebraska infant mortality rate (deaths per 1,000 births) was 5.4, a decrease from 7.0 in 2002. In 2003, 141 Nebraska children died prior to their first birthday.

Nebraska residents lost 1,724 babies under the age of one from 1994-2003. Birth defects, 25% of deaths, were the number one cause of infant death during these years, while 15% were attributed to Sudden Infant Death Syndrome (SIDS). Premature births constitute approximately 8.5% of deaths. Infant mortality rates are generally higher for minority populations. In 2003, white Nebraskans experienced an infant mortality rate of 4.8; while blacks experienced a rate of 15.9, Native Americans 13.2 and those of Hispanic origin had a rate of 5.2.

Low Birth Weight

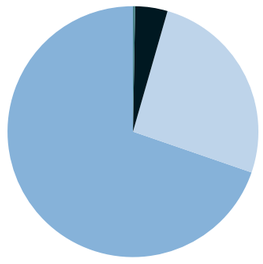
The highest predictor of death and disability in the United States is low birth weight. A newborn weighing below 2,500 grams or 5.5 pounds is considered of low birth weight and a newborn weighing less than 1,500 grams or 3.3 pounds is considered of a very low birth weight. In Nebraska, 1,862 newborns were of low birth weight (7.07%); Of these 1,862, 1.8% (330) were born with a very low birth weight. Both of these categories were higher than in 2003, with more babies being born at these low weights.

Currently, smoking is attributed to close to one-fifth, or 20%, of all low weight births and is the single most known cause of low birth weight. Other factors related to low birth weight are low maternal weight gain, low pre-pregnancy weight, maternal illnesses, fetal infections and metabolic and genetic disorders, lack of prenatal care and premature birth.[1]

Births to Teens

While teen birthrates have been falling in the United States, it has the highest teenage pregnancy rate of all developed countries.[2] Research shows having children as a teenager can limit a young woman's educational and career opportunities, increase the likelihood that she will need public assistance and can have negative effects on the development of her children.[3] In Nebraska, 2,290 babies were born to girls age 19 and under in 2004. This continues to decline from previous years. Across a 10-year span since 1995, 7,992 were born to mothers ages 17 and under. Of the 696 babies born to teen mothers ages 10-17 in 2004, 527 had white mothers, 117 were born to black mothers, 35 had Native American mothers, and six were born to Asian mothers. Adolescent females of Hispanic ethnicity gave birth to 177 babies.

NEBRASKA TEEN BIRTHS BY AGE OF TEEN 2004



Source: Vital Statistics, HHSS

Out-of-Wedlock Births

The risk of having children with adverse birth outcomes, such as low birth weight and infant mortality, are greater for unmarried mothers than for married mothers. Children born to single mothers are also more likely to live in poverty than children born to married couples.[4] The likelihood that a mother will be married upon the birth of the child increases with the age of the mother. In 2004, 93.4% (650) of the mothers age 17 and under were not married upon the birth of their child.

Immunizations

The national goal set by the U.S. Centers for Disease Control and Prevention (CDC) is that 90% of all children be immunized (except for preschool boosters) by the age of two. According to the National Immunization Survey for 2004, 82.3% of Nebraska two-year-olds have received four DTaP (diphtheria-tetanus-pertussis) shots, three polio shots, one MMR (measles-mumps-rubella) shot, three HIB (H. influenza type b) and three Hepatitis B immunizations. The 2004 U.S. national average was 80.9%.
In Nebraska, Varicella (chicken pox) vaccine rates continued to increase from 75.3% in 2003 to 82.2% in 2004. The U.S. national average for varicella vaccine was 87.5%, also an increase.

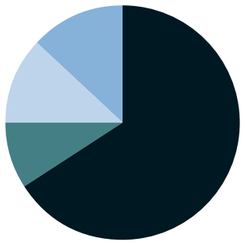
Maria, 9

There were 97 cases of pertussis (whooping cough) reported in Nebraska in 2004, primarily in teens and young adults. This is an astounding increase in cases of pertussis from 2003, which had 15. Generally, the disease does not have a strong effect on older children or adults, however it can be easily passed to young children who may end up hospitalized. Although there have been no deaths in recent years, pertussis is a potentially deadly disease for young children. The Centers for Disease Control and Prevention along with the American Academy of Pediatricians and the American Academy of Family Physicians recommended in 2005 that the newly licensed tetanus, diphtheria and acellular pertussis booster dose (Tdap) be given at the 7th grade visit instead of Td which contains no pertussis.

Access to Health Care

Uninsured children tend to live in employed families that do not have access to insurance. Most often in these cases the employer does not offer insurance, the insurance offered is too expensive or the insurance does not cover all of the necessary medical needs of the family. Many of these uninsured children are eligible for Kids Connection. Kids Connection provides low cost health care coverage for children living in families at or below 185% of the federal poverty level. Kids Connection includes both the State's Children's Health Insurance Program (SCHIP) and the Nebraska Medical Assistance Program (Medicaid). Kids Connection provided health coverage for 134,861 children, nearly 30% of all Nebraska children 18 and under in 2004.

NEBRASKA MEDICAID AVERAGE MONTHLY ELIGIBLE PERSONS BY CATEGORY 2004

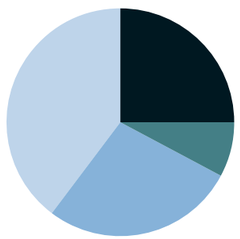


TOTAL: 204,869

- 66% children (134,861)
- 9% aged (18,401)
- 12% ADC adults (24,963)
- 13% blind and disabled (26,644)

Source: HHSS

NEBRASKA MEDICAID VENDOR EXPENDITURES BY ELIGIBILITY 2004



TOTAL: $1,315,682,006

- 25.2% children ($331,041,975)
- 7.7% ADC adults ($101,315,021)
- 27.7% aged ($364,043,928)
- 39.5% blind and disabled ($519,281,083)

Source: HHSS

Child Deaths

Slightly over half of child deaths are attributed to accidents in Nebraska. Child deaths include any child between the ages of 1 and 19. While 2004 statistics were not available in time for this report, in 2003, 38% of the 162 total child deaths were due to motor vehicle accidents, a decrease from 2002. Fourteen percent of the deaths were due to non-motor vehicle accidents. Ten child deaths were attributed to cancer, 17 children were lost to suicide and 10 to homicide in 2003. According to the 2005 National Kids Count Data Book, Nebraska is ranked 27 out of 50 states and the Virgin Islands for rate of teen (ages 15-19) deaths by accident, homicide and suicide. Substance abuse is often associated with deaths due to suicide and homicide.

SELECTED CAUSES OF DEATH, BY FREQUENCY AGES 1-19 IN NEBRASKA, 1994-2003

CAUSES	FREQUENCY
Motor Vehicle Accidents	619
Non-Motor Vehicle Accidents	241
Suicide	174
Homicide	132
Cancer	119
Birth Defects	68
Heart	61
Infectious/Parasitic	28
Asthma	25
Pneumonia	17
All Other Causes	280
TOTAL	**1,764**

Source: HHSS

Blood Lead Levels

In 2004, 20,037 children in Nebraska under six years old were tested for elevated blood lead levels and 572 were considered to have blood lead levels in the range where detrimental effects on health have been clearly demonstrated. This appears to be a dramatic decrease over previous years. However, it is difficult to obtain the number of children poisoned as some parents do not bring children back into clinics for confirmatory tests. Elevated blood lead levels can be attributed to: increased behavioral problems, malnutrition, significant detrimental physical and cognitive development problems. Lead poisoning can be fatal. Blood lead testing is recommended for all children at 12 to 24 months of age and any child under seven years of age who has been exposed to lead hazards.

Children are commonly exposed to lead through lead-based paints often present in houses built prior to 1950. Some homes built as recently as 1978 may also contain lead-based paint. The best way to protect children who are at risk by living in homes with lead-based paint is to maintain freshly painted walls to avoiding chipping and peeling of the paint. It is also important to keep these areas clean and dust free.

Nathan, 6

Mental Health and Substance Abuse Treatment

The Nebraska Health and Human Service System (HHSS) funds selected mental health and substance abuse services for children. Children who utilize these services are most often from lower income Nebraska families or are involved in the court system. Services paid for by private insurance are not included in the data and, therefore, the total is an underestimate of the number of children receiving these services.

Regional Centers

The Adolescent and Family Services (AFS) program at the Lincoln Regional Center (LRC) consists of a six-bed inpatient program located on the Regional center campus and several residential programs for adolescents – the 20-bed Adolescent Psychiatric Residential Program and three 8-bed residential and group home programs. The inpatient program served 74 youth in fiscal year of 2004. The Adolescent psychiatric residential and group home programs served 39 youth. (These are duplicated counts; some youth may have been served in more than one program.)

Hastings Regional Center (HRC) operates a chemical dependency program for youth from the Youth Rehabilitation and Treatment Center in Kearney. During fiscal year of 2004 they served 135 youth in this program and helped 3,988 youth through Youth Treatment group meetings. Seven 18 year olds were served in the HRC adult psychiatric programs.

The Norfolk Regional Center does not have any specialized programs for children or adolescents; however, in fiscal year of 2004 they served eight persons who were 18 years old.

Community-Based Services

Mental health and substance abuse services are provided to youth in an array of prevention and treatment services. Mental health services include professional Partner Program (a community based multi-systemic intensive case management approach), crisis respite (a temporary care giver relieving family for short periods of time either in the home or at another location) and traditional residential and non-residential therapy. Substance abuse services funded for youth include intensive short term residential programs on regional center campuses to community based residential and non-residential alternatives (most notably youth outpatient therapy). Substance abuse prevention services are conducted by community based programs across the state in an effort to repeatedly carry the message of no use before age 21, or in the case of tobacco products – age 18.

Approximately 3,507 Nebraska children ages 0-18 received community-based mental health and substance abuse services in the most recent fiscal year. Out of those children, 2,781 received mental health services only, 517 received substance abuse services only and 209 received both mental health and substance abuse service.

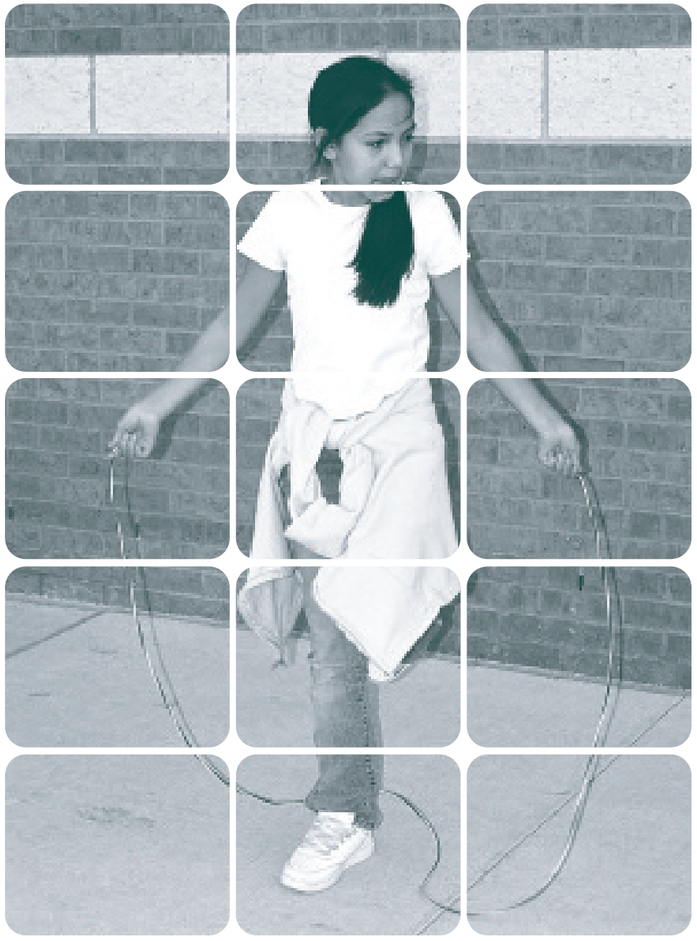
Over 14,000 prevention events have occurred statewide reaching an estimated population of 1,497,600. Nebraska print and electronic media outlets provided 18 statewide media events reaching an estimated target audience of 2,200,000 Nebraska youth, representing the repeated message of no use targeted at youth and young adults.

Youth Risk Behavior Survey

Developed by the National Centers for Disease Control and Prevention and prepared by Nebraska Health and Human Service System (HHSS), the Youth Risk Behavior Survey (YRBS) includes self-reported health information from a sample of Nebraska 9-12 graders in 2003. This survey is given every two years. The goal of the report is to determine and reduce common youth health risks, increase access and delivery to health services and positively affect the often risky behavioral choices of youth. It is important to note, not all of Nebraska's school districts participate in this survey, including Omaha Public Schools, the largest district in the state. There are six categories of health risk behaviors included in the YRBS survey:

- Behaviors that result in unintentional and intentional injuries
- Tobacco use
- Alcohol and other drug use
- Sexual behaviors that result in HIV infection, other sexually transmitted diseases and unintended pregnancies
- Dietary behaviors
- Physical activity

Source: The 2003 Youth Risk Behavioral Survey of Nebraska Adolescents



Alma, 11

Alcohol and Other Drugs

Unfortunately, other surveys support the YRBS finding that alcohol is heavily used by youth in Nebraska. Forty-six percent of the students surveyed had consumed alcohol in the last 30 days prior to the survey and 32% had reported episodic heavy drinking in that same time period. While this is a small decrease from the previous report, it is still of concern. The report goes on to say that youth alcohol use is associated with increased occurrence of unprotected sex and sex with multiple partners, marijuana use, lower academic performance and fighting. Some of the other drugs youth utilized were marijuana (18%), inhalants such as glue, paints, or aerosols (4%), methamphetamines (6%) and cocaine (3%).

Tobacco

In Nebraska, 24% of the students surveyed report that they currently smoke cigarettes. Females report a higher usage of cigarettes, with just over 25% of teen girls reporting they currently smoke. Sixty percent of those surveyed reported they had smoked at some point in their life. In addition, 10% indicated they currently use smokeless tobacco and 18% use cigars.

Motor Vehicle Crashes

The leading cause of deaths among Nebraska youth age 15-24 is automobile crashes. According to the YRBS, 39% of students reported, in the last 30 days, riding in a vehicle driven by someone who had been drinking alcohol. In addition, 21% had driven a motor vehicle themselves one or more times in the past 30 days when they had consumed alcohol. According to the Nebraska Department of Roads, in 2004, 38 Nebraska children 17 years of age and younger died in motor vehicle traffic accidents and 365 suffered disabling injuries due to accidents. In the past 10 years 424 Nebraska children have died due to vehicle accidents.

Teen Sexual Behavior

According to the YRBS, 43% of the adolescents surveyed reported that they had experienced sexual intercourse at least one time in their life, an increase of 1% over 2001. Thirty-one percent of the adolescents who reported having had sexual intercourse used alcohol or drugs prior to their last sexual intercourse experience. The majority of these teens, 60%, reported using a condom the last time they had sexual intercourse, lessening their chances of contracting a sexually transmitted disease or becoming pregnant. Five percent of the respondents reported having had sexual intercourse before the age of 13, and 12% had experienced intercourse with four or more people during their life.

Obesity, Dieting and Eating Disorders

The YRBS student respondents were requested to include their height and weight measurements on their surveys. In 2003, 33% of students described themselves as being either slightly or very overweight. However, only 10% were actually considered to be overweight, or at risk of becoming overweight, based on their Body Mass Index (BMI). Forty percent of the females surveyed described themselves as overweight, however only 10% were at risk of becoming overweight, or were overweight, according to their BMI. Although only 10% of the female students met the BMI criteria for overweight or at risk of becoming overweight, 65% of the females surveyed reported that they were trying to lose weight at the time of the survey. Twenty-five percent of the males surveyed were also trying to lose weight at the time of the survey.

Thirty-two percent of the students reported that they did not participate in sufficient vigorous physical activity and 8% did not participate in sufficient moderate physical activity. Forty-one percent of the students reported insufficient, or no level of, physical activity on the 30 days preceding the survey. Eighty-four percent ate less than five servings of fruits and vegetables per day during the seven days prior to the survey and 82% reported that they did not regularly consume milk during the seven days preceding the survey.

Diana, 7

policy box

HOME VISITATION

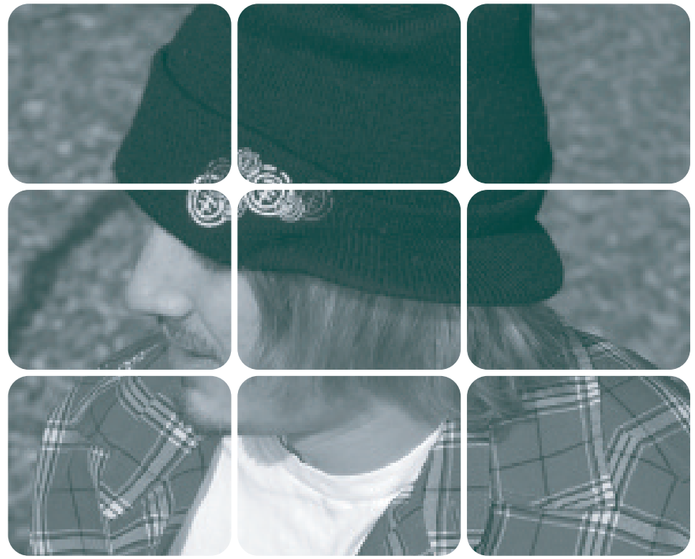
Child advocates and public officials have been working together in the past few years to develop policy initiatives to prevent any increase in the number of deaths of Nebraska children due to child maltreatment. In the winter of 2003, the Governor's Children's Task Force handed down 28 recommendations for improving the child protection system in a report entitled "A Roadmap to Safety for Nebraska's Children." The first of these recommendations would improve the quality of life for newborns by the implementation of voluntary universal home visitation services for new parents on a statewide basis.

Senator Gwen Howard achieved legislative changes toward this recommendation in her first year as the representative for District 9 in Omaha. The home visitation bill, LB 264, passed easily through the Legislature and was approved by Governor Heineman on March 22, 2005. This new law is aimed at preventing child abuse and neglect by intervening early and providing vital information for new parents. The law allows the Department of Health and Human Services (HHS) to provide home visitation services as part of their social services program, and further requires that HHS include in their caseworker reports to the Legislature specific information about sizes of caseloads for each child welfare services caseworker.

LB 264 authorizes HHS to provide secondary prevention programs directed at recognizing, assessing, and achieving change in high-risk situations. Secondary programs may include prenatal programs, perinatal bonding, interaction with infants, support for parents and infants in need of extra services, home visitor programs, mutual aid programs, child screening for early identification and remediation of social and health problems, and education for parenthood. LB 264 provides authorization for prevention programs and is discretionary. Therefore, Voices will continue to follow the development of programs based upon the appropriation and direction of the legislature, and will continue to advocate for the availability of visits for all newborns, regardless of income.

Juvenile Justice

Adolescents and youths can find themselves involved in the juvenile justice system for a variety of reasons, ranging from truancy to homicide. Family problems including domestic violence, poverty, mental health issues and self-esteem can all be factors that influence a juvenile's behavior. Our responsibility as adults is to insure that once a youth has entered the system, he or she has quality resources such as adequate mental health treatment and educational experiences available that will lead to success.



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Juvenile Arrests

In 2004, 15,344 Nebraska juveniles were arrested, an increase over the last several years. While female juvenile offenders comprise over 32% of all juvenile arrests, they outnumber male offenders in the number of arrests for offenses against family and children and have doubled the number of felony assaults from 2003. Male offenders make up approximately 68% of all juvenile arrests.

SELECTED* NEBRASKA JUVENILE ARRESTS BY OFFENSE AND GENDER 2004

OFFENSE	MALES	FEMALES	TOTAL
Larceny – Theft	1,896	1,307	3,203
Liquor Laws	1,295	903	2,198
All Other Offenses	1,657	857	2,514
Misdemeanor Assault	1,190	519	1,709
Drug Abuse Violations	902	257	1,159
Vandalism-Destruction of Property	969	181	1,150
Weapons: Carrying, Possessing, etc.	177	7	184
Felony Assault	104	28	132
Sex Offense (except forcible rape & prostitution)	107	6	113
Arson	63	10	73
Robbery	65	4	69
Forgery & Counterfeiting	23	11	34
Forcible Rape	16	0	16
Prostitution	2	1	3
Offenses Against Family and Children	12	18	30
Murder & Manslaughter	3	1	4

Source: Nebraska Crime Commission

*This does not include all arrests

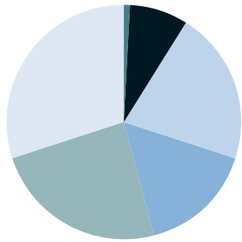
Probation

In 2004, there were 5,860 juveniles supervised on probation while there were 5,707 juveniles supervised in 2003. This is a 2.6% increase from last year. During 2004, statewide, 2,438 juveniles satisfactorily completed probation while there were 2,696 juveniles who completed probation satisfactorily in 2003. This is a decrease of nearly 10%.

In 2004, five juveniles were convicted of homicide and 58 juveniles were convicted of sexual assault. Additionally, there were 113 juveniles tried in adult court.

According to the Nebraska Probation Management Information System (NPMIS), from 2003 to 2004, the number of misdemeanor juvenile cases decreased 11.6% and the number of felony juvenile cases decreased 2.5%.

JUVENILE ARRESTS BY AGE, 2004



Source: Nebraska Crime Commission

Youth Rehabilitation and Treatment Centers (YRTC)

The two Youth Rehabilitation and Treatment Centers in Nebraska are located in Kearney (established for males in 1879) and Geneva (established for females in 1892). The YRTC Kearney mission is: To help youth live better lives through effective services affording the youth the opportunity to become law abiding and productive citizens. The YRTC in Geneva's mission is: To protect society by providing a safe, secure and nurturing environment in which the young women whom come to us may learn, develop a sense of self, and return to the community as productive and law abiding citizens. In the fiscal year 2003-2004, 467 males were admitted for treatment to Kearney and 123 females to Geneva for a total of 590 youth in YRTC care from July 2003 – June 2004. This was a decrease of 44 total YRTC commitments during the previous year.

Geneva provided services for an average of 90 females per day. The average female committed to Geneva in 2003-2004 was 16 years old at admission and remained there 10 months. The top offenses were theft (32%), assault (23%) and auto theft (12%). The majority of females placed at YRTC Geneva were white 54%, 23% were black, 13% were Hispanic and 10% were Native American.

YRTC Kearney had an average daily population of 187 in 2003-2004, a slight decrease of 5 from the previous year. Males at Kearney remained an average of 180 days, and 62% were 16-17 years of age. Most young men committed to Kearney were white (52%), 20% were black, 16% were Hispanic, 9% were Native American, 1% were Asian and 2% were classified as "other." The major offenses committing males to YRTC Kearney were theft (22%), assault (15%) and possession of drugs (12%).

Adult Jail and Parole for Juveniles

In 2004, 161 Nebraska youth ages 18 and under were processed through the adult system and housed in adult prisons. Of these juveniles, roughly 49% were incarcerated for robbery, burglary or theft, while the remaining were held for drug offenses, weapon offenses, sex offenses, homicide and other crimes. One youth was held for homicide in 2004. Studies show trying juveniles in adult court is not an effective intervention in reducing juvenile crime, however it is used nationally. "Youth in the adult system are more likely to recidivate – and to recidivate more quickly and with serious offenses – than youth who are prosecuted through the juvenile system."[1]

impact box

TEEN COURT DIVERSION PROGRAM

Teen Court Diversion programs are based on the belief that not all juvenile delinquency cases are best handled through a formal court hearing or adjudication process. Teen Court is a voluntary, positive alternative that can provide more appropriate methods of treating youth charged with an offense. Agencies operating and administering youth court programs include juvenile courts, juvenile probation departments, law enforcement, private non-profit organizations, and schools. Participants are first time misdemeanor offenders between the ages of 12-18, who resolve their legal difficulties in front of a jury of their peers, without incurring a criminal record. The jury and judge, comprised of community youth volunteers, consider what consequences best help educate and rehabilitate the juvenile defendant, and restore the community. The program emphasizes that crime damages people, communities, and relationships.

Teen Court seeks to achieve a balance between the needs of victims, offenders, and the community by building on positive community values. The youth participants must accept responsibility for their actions prior to appearing before the Teen Court Jury. In addition, since the majority of Teen Courts require defendants to perform community service hours as part of their sentence and utilizes community members as adult volunteers, many local nonprofit agencies have a chance to work directly with youth in meaningful community service.

In Lancaster County, CEDARS Youth Services, a non-profit organization, is currently in its seventh successful year of operating a Juvenile Diversion Teen Court. CEDARS Juvenile Services programs strive to help young people avoid delinquent and criminal behavior and to facilitate the individual's full and just participation in society. The program operates under the philosophy of "Restorative Justice," which holds youth accountable for their actions and provides them with opportunities to develop skills that prevent them from re-offending. In addition, participation in Teen Court often causes youth to rethink their views on delinquent behavior and lead them to adopt more pro-social attitudes. This outcome ultimately can enhance public safety. The youth volunteers have created a peer-review program, which has served 1,202 youth and resulted in a repeat offense, rate of only eight to ten percent.

In 48 states, peers under the age of 18 voluntarily staff Teen Courts. These programs simultaneously offer education and "hands-on" experience in the legal system to the volunteers. The high level of youth participation affords communities an opportunity to empower youth to address the problem of juvenile crime in their community. It gives them an opportunity to meet and interact with peers from diverse economic, social, and ethnic backgrounds; and interact with positive adult role models. It is this type of program and experience that can help youth take pride and ownership in the health and well-being of their communities.

Source: CEDARS Juvenile Services and youthcourt.net

Nutrition

Nutrition serves as the foundation for children's health, academic achievement and overall development. Being undernourished can inhibit a child's ability to focus, absorb information and exhibit appropriate behavior at home and school. Good nutrition can prevent illnesses and encourage proper physical growth and mental development. Supplemental food programs that include access to nutritious foods and offer education can assist families in providing healthy food for their children.

USDA Nutrition Programs

Food Stamps

Food Stamps are cards provided by the United States Department of Agriculture (USDA) to aid families that have incomes at or below 130% of poverty in order to maintain a low-cost, healthy diet. In the year 2004, the use of Food Stamps rose from previous years. Nebraska Health and Human Services (HHS) distributed Food Stamps to an average of 111,435 persons or 47,292 households monthly in 2004. The average payment was $187.14 per household and $79.42 per person totaling $106,204,774.36. There were 78,230 children ages 0-18 found eligible to receive Food Stamps.

School Lunch

Families are eligible for free or reduced price lunches based on their income level through the USDA School Lunch Program. Families must have an income at or below 130% of poverty to receive free lunch and at or below 185% of poverty to receive reduced price meals. Through this program the USDA subsidizes all lunches served in schools. During the 2003-2004 school year, 485 school food authorities participated at 1,023 sites. An average of 90,186 children received free and reduced price lunches, while 105,405 children were found income eligible. Of the 15,219 unaccounted for children, it is unknown how many chose not to participate in the program and how many attend a school that does not offer free or reduced lunches.

School Breakfast

The USDA provides reimbursements to schools for breakfast as they do for lunch. Unfortunately fewer schools choose to participate in the breakfast program. During the 2003-2004 school year, 605 schools in 237 districts participated in the school breakfast program. Each month, an average of 4,658, children participated in the free/reduced price school breakfast program.

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A total of $38,582,671.70 was spent, or reimbursed, for all breakfast and lunches in fiscal year 2004 in Nebraska.

Summer Food Service Program

The USDA Summer Food Service Program (SFSP) was created to meet the nutritional needs of children and low-income adults during the summer. An average of 7,322 Nebraska children participated in the SFSP in 2004. Only 20 of the 93 Nebraska counties offer the SFSP, but this is up from 19 counties in 2003. Due to the sites that offer two meals daily, the actual unduplicated number of child participants may be lower than the total given as one child may be counted twice for receiving both breakfast and lunch daily.

Commodity Distribution Program

The USDA purchases surplus commodities through price support programs and designates them for distribution to low-income families and individuals through food banks, soup kitchens and pantries. In 2004, 81,039 Nebraska households were served through the Commodity Distribution Program, an average of 7,753 households per month. A monthly average of 32,513 meals were served in soup kitchens through this program, totaling 390,158 meals.

Child and Adult Care Food Program

In 2004, an average of 6,546 daily lunches were provided in child and adult care centers and 10,962 in homes through this food program.

Commodity Supplemental Food Program (CSFP)

Women who are pregnant, breast-feeding and post-partum or families with infants and children to age six who are at or below 185% of poverty are eligible for the USDA Commodity Supplemental Food Program. The program provides surplus commodity foods, such as non-fat dry milk, cheese, canned vegetables, juices, fruits, pasta, rice, dry beans, peanut butter, infant formula and cereal. A monthly average of 1,437 women, infants and children were served by CSFP totaling 17,244 food packages for fiscal year 2004. Seniors, age 60 or older, who are at or below 130% of poverty may also participate in the program. Seniors received 162,924 food packages averaging 13,577 per month. There are 46 CSFP distribution sites serving all 93 counties.

WIC PARTICIPANTS

Year	Average Monthly Program Participants
1994	33,592
1995	35,059
1996	35,376
1997	32,351
1998	31,107
1999	32,379
2000	32,194
2001	33,797
2002	36,454
2003	37,730
2004	39,087

Source: HHSS

NE WIC PARTICIPATION BY CATEGORY FOR FEDERAL FISCAL YEAR 2004

Breastfeeding Women	2,417
Postpartum Women	2,841
Pregnant Women	4,264
Infants	9,939
Children	19,626
Total	**39,087**

Source: HHSS

WIC

The special Supplemental Nutrition Program for Women, Infants and Children (WIC) is a short-term intervention program designed to influence lifetime nutrition and health behaviors in a targeted, high-risk population. Nebraska WIC served an average of over 39,087 participants per month through 120 clinics in 2004. WIC provides nutrition and health information, breastfeeding support and supplemental foods such as milk, juice, cheese, eggs and cereal to Nebraska's pregnant, postpartum and breastfeeding mothers, as well as infants and children up to age five who have a nutritional risk and meet the income guidelines of 185% of poverty. Parents, guardians and foster parents are encouraged to apply for benefits. Of the 26,323 babies in Nebraska in 2004, 43% (11,301) were on WIC. Participation in the WIC program has continued to increase steadily over the past four years. Average participation per month was 39,087 (9,522 women, 9,939 infants and 19,626 children) in 2004. Costs for food benefits and nutrition services average approximately $591 per year in Nebraska for a pregnant woman on WIC. Participation in the program helps ensure children's normal growth, reduce levels of anemia, increase immunization rates, improve access to regular health care and improve diets. Children participating in WIC also demonstrate better cognitive performance. WIC expenditures can prevent the need for more expensive intervention later. National studies have shown Medicaid costs were reduced on average between $12,000 and $15,000 per infant for every very low birth-weight (less than 1500 grams) prevented.

impact box

SCHOOL BREAKFAST SCORECARD: NEBRASKA FAILING

The number of children from low-income families receiving free/reduced school breakfast increased by almost 354,000 in the 2003-2004 school year, a 5.2% increase from the year before. This is the largest increase in participation rate in nine years.

The national ratio of participation is 43 children eating free or reduced breakfast for every 100 children eating free or reduced school lunches. Unfortunately for low-income Nebraska children, we are one of seven states serving breakfast to fewer than one in three low-income children eating school lunch; with only five states falling below our ratio of 32.4:100. Nebraska has 88,563 students enrolled in the Free/Reduced School Lunch Program, and only 28,263 students enrolled in the Free/Reduced School Breakfast Program, ranking us 45 out of 50 states. Nebraska ranked higher than only Alaska, Illinois, Utah, New Jersey and Wisconsin.

Nebraska is also one of six states operating school breakfast in fewer than 60 percent of the schools offering school lunch; giving us the ranking of 47/50 state and the District of Columbia in this category. Nebraska ranked higher than only Wisconsin, Ohio, Connecticut, and New Jersey in this category.

The School Breakfast Scorecard: 2004 report put out by the Food and Research Action Center estimates that if Nebraska brought the ratio of participating children to a level commensurate with the positive national trends (55 students per 100 receiving free/reduced school lunch), an additional $4,057,539 in federal funds would be generated each year for Nebraska schools.

Information taken from the "School Breakfast Scorecard: 2004" November, 2004, Food Research and Action Center (FRAC)

Out-of-Home Care & Adoption

Nebraska children may be placed in out-of-home care as result of abusive or neglectful behavior by their parent/guardian or their own delinquent or uncontrollable behavior. Nebraska Department of Health and Human Services (HHS) is responsible for most of the children in out-of-home care because they are court ordered into care as wards of the state. There are a small number of children placed in private residential facilities who are not considered wards of the state. A child in out-of-home care may reside in a variety of placements such as foster homes, group homes, residential treatment facilities or juvenile correction facilities.

State Foster Care Review Board (FCRB)

In 1982, the FCRB was created as an independent agency responsible for reviewing the plans, services, and placements of children who have been in out-of-home care for six months or longer. These reviews fulfill Federal IV-E review requirements. Over 350 trained citizen volunteers serve on local FCRB boards to engage in this important review process. Completed reviews are shared with all parties legally involved with the case. The FCRB also has an independent tracking system for all Nebraska children in out-of-home care and regularly disseminates information on the status of those children. With the exception of the approved and licensed foster care home data, all of the data in this section was provided by the FCRB through their independent tracking system.

How Many Children Are in Out-of-Home Care?

In 2004, a total of 10,361 Nebraska children were in out-of-home care at some point. This was an increase of 221 children over the previous year. On January 1, 2004 there were 5,522 children in out-of-home care, during the year 4,839 entered care while 4,140 exited. An additional 138 children who left care prior to 2004 had their exit reported during 2004, leaving 6,083 children in care on December 31, 2004, 561 more children in care than the previous year. Of the 4,839 children who entered care in 2004, 3,208 (66%) were placed in out-of-home care for the first time and 1,631 for the second or more times. Of the 6,083 children in care on December 31, 2004, 5,747 were HHS wards.

Neglect is the most frequently recorded cause for removal of a child from their parent's or guardian's home. Neglect has several forms that range from outright abandonment to inadequate parenting skills which affect child well-being. The child's behavior is the second most prevalent cause of placement followed by physical abuse.

In 2003, a change was made in the method for collecting data documenting the reasons for entering care. Previously, each category was broken into subcategories. Currently, no subcategory data is collected. Due to the changes, it is difficult to compare the reasons for entering out-of-home care to previous years.

REASONS CHILDREN ENTERED OUT-OF-HOME CARE IN 2004

CATEGORY	ALL CHILDREN REVIEWED[1]		CHILDREN BY NUMBER OF REMOVALS			
			Reviewed children who were in foster care for the first time[1]		Reviewed children who had been in foster care at least once previously[1]	
Neglect[2]	2,274	59.5%	1,374	60.1%	900	58.8%
Child's Behaviors[3]	1,255	32.9%	316	13.8%	939	61.3%
Physical Abuse	801	21.0%	442	19.3%	359	23.5%
Housing substandard/unsafe	728	19.1%	450	19.7%	278	18.2%
Parental Drug Abuse	933	24.4%	679	29.7%	254	16.6%
Abandonment	479	12.5%	302	13.2%	177	11.6%
Caretaker Inability to Cope due to Parental Illness/Disability	382	10%	200	8.7%	182	11.9%
Parental Alcohol Abuse	480	12.6%	323	14.1%	157	10.3%
Parental Incarceration	407	10.7%	253	11.1%	154	10.1%
Child's Mental Health[3]	209	5.5%	88	3.9%	121	7.9%
Sexual Abuse[4]	324	8.5%	192	8.4%	132	8.7%
Relinquishment	67	1.8%	10	.44%	57	3.7%
Child's Drug Abuse	116	3.0%	25	1.1%	91	5.9%
Child's Alcohol Abuse	66	1.7%	23	1.0%	43	2.8%
Child's Illness	0	0%		0%	0	0.8%
Child's Disabilities	46	1.2%	21	.92%	25	1.6%
Death of Parent(s)	20	0.5%	6	0.3%	14	0.9%
Child's Suicide Attempt	21	0.6%	10	.44%	11	0.7%
Other	34	.90%	24	1.05%	10	0.7%

1 Up to ten reasons for entering out-of-home care could be identified for each child reviewed. 2,288 of the 3,819 children reviewed were in their first removal from the home, 1,531 of the 3,819 reviewed children had been removed from the home at least once before.

2 Neglect is the failure to provide for a child's basic physical, medical, educational, and/or emotional needs.

3 Many of the behaviors identified as a reason for children and youth to enter out-of-home care are predictable responses to prior abuse or neglect.

4 Children and youth often do not disclose sexual abuse until after removal from the home. This figure includes only sexual abuse identified as an initial reason for removal and does not reflect later disclosures.

Source: State Foster Care Review Board

There are a variety of placement possibilities for children in out-of-home care. Of the 6,083 children in care on December 31, 2004, there were 2,704 (44%) in foster homes, 1,027 in group homes or residential treatments centers, 1,062 placed with relatives, 574 in jail/youth development center, 105 in private adoptive homes not yet finalized and 276 in emergency shelter. The remaining children were involved in Job Corps/school, centers for the disabled, psychiatric, medical, or drug/alcohol treatment facilities, or child caring agencies. Lastly, 109 were runaways/ whereabouts unknown and 82 were living independently as they were near adulthood.

Licensed and Approved Foster Homes

In December 2004, there were 2,195 licensed foster homes, a decrease from 2,209 the prior year. Licensed foster homes are required to pass background checks consisting of reference checks, a local criminal record check and child abuse registry checks. These providers must also participate in a series of interviews and complete initial and ongoing training. In comparison, *approved* providers are usually relatives or individuals who have known the child or family prior to placement and are not required to pass the same checks as licensed providers. Due to the lack of training required, approved providers may provide care for the child or children from one family only. Approved providers must pass an in-home evaluation, a child abuse registry check and local criminal record check.

Lack of Foster Care Homes

According to HHS, a total of 3,708 approved and licensed homes were available in Nebraska in 2004. Unfortunately, this shows a continued loss in the number of foster care homes available for children. Foster care providers are desperately needed for individual homes and offer the most ideal, least institutionalized environment for children placed in out-of-home care.

If you are interested in making a difference in a child's life by becoming a foster parent, please call 1-800-7PARENT for information.

Multiple Placements

Unfortunately, it is not unusual for a child to be moved repeatedly while in out-of-home care. The FCRB tracking system counts each move as a placement; therefore, if a child is placed in a foster home, then sent to a mental health facility, then placed in a different foster home, three placements would be counted; however, a hospitalization for an operation would not be counted. Again, the ideal situation for a child placed in out-of-home care is to experience only one placement creating the consistency recommended for positive child well-being.

NUMBER OF PLACEMENTS EXPERIENCED BY CHILDREN IN OUT-OF-HOME CARE

Number of Placements	In Care on Dec. 31, 2004
4-9 Placements	31% (1,894 of 6,083)
10 or more placements	16% (961 of 6,083)

Source: State Foster Care Review Board

Race and Ethnicity

Minority children continue to be over-represented in the Nebraska out-of-home care system. Minority children make up approximately 15% of Nebraska's child population (2000 Census), however they represent at least 34% of children in out-of-home care.

OUT-OF-HOME CARE CHILDREN BY RACE (Dec. 31, 2004)

Race	Percent in Care
White	65.5%
Black	16.1%
Other/not known	10.2%
Native American	7.0%
Asian	1.2%
Hispanic	10.4%

Source: State Foster Care Review Board
Note: Total does not equal 100%, as Hispanic origin is ethnicity, not race

Adoption Services

As adoption is the preferred permanency plan for children who cannot be safely reunited with their biological family; efforts are being made to encourage the adoption of state wards. The Nebraska Foster and Adoptive Parent Association (NFAPA), in conjunction with Nebraska Health and Human Services and Nebraska Public Policy Group, has developed a book of information on adoption and adoption subsidies for adoptive parents.

Nebraska received $293,316 in adoption incentive funds as a bonus from the U.S. Department of Health and Human Services and as a part of the Adoption and Safe Families Act of 1997. This incentive money was for an increase in adoption of state wards.

The adoption incentive funds are being utilized to fund the Answers for Family website, video conference training, video training on the Multi-Ethnic Placement Act, recruitment and training of Foster/Adoptive parents and family group conferencing, which is provided through a contract with UNL Center For Children, Families and the Law.

In 2004, there were 305 adoptions of state wards finalized in Nebraska. This number may be understated due to the number of reports from HHS indicating that children left care, but not the reason for leaving.

policy box

LAWSUIT FILED ON BEHALF OF NEBRASKA FOSTER CHILDREN

After nearly two years of reviewing thousands of documents, including state and federal audits, interviewing Nebraska judges, attorneys and child advocates, and hundreds of Nebraska foster and adoptive parents, Children's Rights, a child welfare group based in New York City, and the Nebraska Appleseed Center for Law in the Public Interest, aided by attorneys from four Nebraska law firms and an international firm based in Chicago, filed a lawsuit in U.S. District Court this last September on behalf of foster children in Nebraska. The lawsuit alleges that the state fails to protect foster children and fails to provide them with adequate services. "Nebraska's mismanaged, overburdened and under-funded foster care system routinely further harms (foster children) and allows them to deteriorate, without the basic care, services, protection and opportunities for a permanent home that are necessary for their physical, emotional and psychological development and well-being," the lawsuit states.

Five foster children are named as plaintiffs in the class action suit, representing the more than 6,000 children in state custody as the result of abuse, neglect, truancy or being considered uncontrollable. The lawsuit seeks a court order requiring Nebraska to provide the legally mandated care, treatment, and services to the foster children in the state's custody. Among the alleged deficiencies:

A severe shortage of foster homes. **As a result, children are too often placed in the first available home, rather than receiving a placement suitable to their needs. Foster homes are regularly overcrowded, sometimes housing more than six children at a time (many of them with special needs) preventing adequate parental supervision, placing children at heightened risk of harm.**

Low pay to foster parents. **Nebraska ranks 50th in the nation in payment to foster parents, paying less than $8 a day per child, or $222 per month. The federal government estimates the average monthly cost of raising a child in the rural United States is $775 and even more in the urban Midwest.**

Leaves children in state custody too long. **Children spend a large portion of their lives in foster care because of inappropriate case management. Nebraska foster children are routinely denied opportunities for adoption, and many are discharged from the foster care system at or around the State's age of majority without the life skills necessary for them to live independently.**

Moves foster children frequently and to inappropriate placements. **Children get bounced from placement to placement, or are mistreated or receive inappropriate services while in foster care.The 2004 annual report issued by the Nebraska Foster Care Review Board found that 50 percent of all children in "out-of-home" foster care as of the last day of 2003 had experienced four or more placements during their time in foster care, and over 30 percent of those children had been moved six or more times.**

Lack of basic health services for foster children. **Nebraska's foster children are routinely denied services necessary to address acute mental problems on the basis of cost, and are also denied timely basic medical examinations and dental health services.**

High caseloads among state caseworkers. **HHS caseworkers responsible for overseeing the care and protection of children in the State's custody often have dangerously high caseloads that are multiples of the national standard of 12-15 foster children per caseworker. As a result of high caseloads, caseworkers are unable to adequately monitor the safety of foster children assigned to them. For January 2005, at least 36% of foster children statewide did not receive a required monthly contact from their caseworker.**

Voices for Children in Nebraska hopes the lawsuit will provide ongoing dialogue and policy implementation aimed at improving the quality of life for children in Nebraska. Executive Director, Kathy Bigsby Moore says, "The children in our foster care system need the attention, and if a lawsuit can create the public will to address long-standing problems, I applaud that."

impact box

NEBRASKA CASA ASSOCIATION

According to the Nebraska Foster Care Review Board there were 5,816 Nebraska children in out-of-home placement as of June 2004. As of that same date, 2,960 abused or neglected children had their cases adjudicated in court. Many of these children will languish for months or years in an over-burdened juvenile justice system that is ill-equipped to meet their special needs. Judges, attorneys, guardians ad litem and case managers have multiple cases. Court Appointed Special Advocates (CASA) in Nebraska are trained volunteers who advocate in court on behalf of one child or one sibling group. Nebraska CASAs spent an average of 46 hours per year on their assigned case. Case managers, attorneys and foster parents may change. The CASA volunteer is often the only adult that remains constant throughout the duration of their court proceedings. CASAs also play a key role in keeping siblings together (Youngclarke, et. al., 2004).

Judges assign CASA volunteers to help gather information on some of the most challenging and complicated juvenile cases. CASAs interview the children, foster parents, parents, teachers, daycare workers and case managers and then write an independent, unbiased report for the presiding judge. Retired Judge J. Dean Lewis states that CASA volunteers provide the judge with critical information about the child and alert them to problems that require intervention (J. Dean Lewis, Oct. 2005). Judges make decisions based in part on factual, unbiased information provided by the CASA report.

Research studies reviewed by Youngclarke et. al. in *"A Systematic Review of the Impact of Court Appointed Special Advocates,"* (2004), show that children who have a CASA volunteer assigned to their case early on:

- *are more likely to have family members present at court hearings*
- *reach permanency, on average, two months sooner than children who did not have a CASA assigned*
- *have fewer foster family placement changes*
- *are more likely to be adopted than children without a CASA*
- *are 50% less likely to reenter the foster-care system once their case is closed*
- *have more services recommended for the child and the family*

Last year 894 Nebraska children were served by over 400 CASA volunteers. Well over 500 children across the state are currently waiting for a CASA.

Source: Nebraska CASA Association.

County Data Notes

1. TOTAL COUNTY POPULATION

Source: 2000 U.S. Census of Population and Housing.

2. CHILDREN 17 AND UNDER

Source: 2000 U.S. Census of Population.

3. CHILDREN UNDER 5

Source: 2000 U.S. Census of Population.

4. BIRTHS IN 2004

Source: Nebraska Health and Human Services System (HHSS).

5. MINORITY CHILDREN (ALL CHILDREN MINUS WHITE NON-HISPANIC ONLY)

Source: 2000 U.S. Census of Population.

6. CHILDREN LIVING IN SINGLE PARENT FAMILIES (SINGLE HEAD OF HOUSEHOLD MAY BE MALE OR FEMALE)

Source: 2000 U.S. Census of Population.

7. PERCENT OF POOR CHILDREN WHO LIVE IN SINGLE PARENT FAMILIES

Source: 2000 U.S. Census of Population.

8. PERCENT OF POOR CHILDREN WHO LIVE IN TWO PARENT FAMILIES

Source: 2000 U.S. Census of Population.

9. PERCENT OF CHILDREN LIVING IN POVERTY

Source: 2000 U.S. Census of Population.

10. PERCENT OF CHILDREN UNDER 5 YEARS OF AGE LIVING IN POVERTY

Source: 2000 U.S. Census of Population.

11. PERCENT OF MINORITY CHILDREN LIVING IN POVERTY

Source: 2000 U.S. Census of Population.

12. PERCENT OF MOTHERS WITH CHILDREN UNDER 6 YEARS OF AGE WHO ARE IN THE LABOR FORCE

Source: 2000 U.S. Census of Population.

13. AVERAGE MONTHLY NUMBER OF FAMILIES ON ADC IN 2004

Source: HHSS.

14. AVERAGE MONTHLY NUMBER OF CHILDREN RECEIVING MEDICAID SERVICES IN 2004

Source: HHSS.

15. NUMBER OF WOMEN, INFANTS AND CHILDREN ELIGIBLE TO PARTICIPATE IN WIC SERVICES IN 2004

Source: United States Department of Agriculture.

16. NUMBER OF WOMEN, INFANTS AND CHILDREN PARTICIPATING IN WIC SERVICES IN 2004

Source: HHSS.

17. AVERAGE NUMBER OF CHILDREN PARTICIPATING IN FREE AND REDUCED BREAKFAST PROGRAM IN 2004

Source: Nebraska Department of Education.

18. AVERAGE NUMBER OF CHILDREN RECEIVING FREE OR REDUCED PRICE SCHOOL LUNCH 2004

Source: Nebraska Department of Education.

19. AVERAGE DAILY NUMBER OF CHILDREN SERVED BY THE SUMMER FOOD PROGRAM IN 2004

Source: Nebraska Department of Education.

20. BIRTHS TO TEEN AGES 10 TO 17 YEARS OLD FROM 1995 TO 2004

Source: HHSS.

21. OUT OF WEDLOCK BIRTHS FROM 1995 TO 2004

Source: HHSS.

22. INFANT DEATHS 1994 TO 2003

Source: HHSS.

23. DEATHS IN CHILDREN AGES 1 TO 19 FROM 1994 TO 2003

Source: HHSS.

24. NUMBER OF INFANTS BORN AT LOW BIRTH WEIGHTS IN 2004

Source: HHSS.

25. HIGH SCHOOL GRADUATES 2003-2004

Source: Nebraska Department of Education.

26. SEVENTH TO TWELFTH GRADE SCHOOL DROPOUTS FOR THE SCHOOL YEAR 2003-2004

Source: Nebraska Department of Education.

27. NUMBER OF CHILDREN WITH VARIFIED DISABILITY RECEIVING SPECIAL EDUCATION FOR THE SCHOOL YEAR 2003-2004

Source: Nebraska Department of Education.

28. COST PER PUPIL (PUBLIC EXPENDITURES) FOR THE SCHOOL YEAR 2003-2004 BY AVERAGE DAILY MEMBERSHIP

Source: Nebraska Department of Education.

29. HEAD START AND EARLY HEAD START ENROLLMENT FOR 2004

Source: Nebraska Dept. of Education (data is self-reported by Head Start programs).

30. CHILDREN IN FOSTER CARE BY COUNTY OF COMMITMENT 2004 TOTAL INCLUDES VOLUNTARY, UNREPORTED AND TRIBAL COURT COMMITMENTS NOT INCLUDED IN THE COUNTY BREAKDOWNS.

Source: Nebraska Foster Care Review Board.

31. REPORTED NUMBER OF YOUTH 19 AND YOUNGER WITH STD'S IN YEARS 1995-2004

Source: HHSS.

32. JUVENILE ARRESTS 2004

Source: Nebraska Crime Commission and Omaha Police Department.

Data included on County Data pages are reflected of county specific data only. Data from agencies that include data from outside sources such as "out of state, other, etc." may not be included.

County Data

Kids Count 2005 Report

	1. TOTAL POPULATION	2. CHILDREN AGES 0-17	3. CHILDREN UNDER 5	4. 2004 BIRTHS	5. MINORITY CHILDREN	6. CHILDREN WITH SINGLE PARENTS	7. % POOR WITH SINGLE PARENTS	8. % POOR TWO PARENTS	9. % CHILDREN IN POVERTY	10. % UNDER 5 IN POVERTY	11. % MINORITY CHILDREN IN POVERTY	12. % WORKING MOM WITH CHILD(REN) UNDER 6	13. FAMILIES ON ADC	14. MEDICAID ELIGIBLE CHILDREN	15. 2004 AVE. MONTHLY WIC PARTICIPATION
ADAMS	31,151	7,616	1,986	455	879	1,434	68	32	10	12	17	76	196	2,464	718
ANTELOPE	7,452	2,050	447	76	50	270	41	59	17	19	39	80	21	597	100
ARTHUR	444	106	23	6	7	15	38	62	15	20	50	83	0	23	12
BANNER	819	236	39	6	21	19	31	69	19	8	69	65	0	63	6
BLAINE	583	153	32	5	3	8	3	97	22	32	0	69	1	55	12
BOONE	6,259	1,822	370	60	43	225	28	72	12	15	18	80	9	329	91
BOX BUTTE	12,158	3,420	797	133	677	650	68	32	14	18	37	71	117	1,065	306
BOYD	2,438	609	123	19	11	67	21	79	20	16	0	77	7	189	65
BROWN	3,525	875	188	40	26	129	45	55	15	22	46	81	4	303	80
BUFFALO	42,259	10,566	2,805	640	1,178	1,941	71	29	10	14	24	79	218	3,115	824
BURT	7,791	2,001	441	70	123	339	56	44	12	9	13	77	31	462	125
BUTLER	8,767	2,443	599	95	84	330	29	71	10	14	33	75	23	477	100
CASS	24,334	6,792	1,699	335	315	1,125	68	32	7	12	5	74	83	1,524	311
CEDAR	9,615	2,828	582	100	57	240	23	77	11	8	0	83	8	423	116
CHASE	4,068	1,025	227	45	79	155	41	59	11	16	15	71	11	249	68
CHERRY	6,148	1,659	380	80	162	295	44	56	13	17	22	75	23	699	170
CHEYENNE	9,830	2,587	628	146	243	544	57	43	12	15	31	76	32	664	143
CLAY	7,039	1,921	409	67	146	256	40	60	13	16	26	76	33	506	133
COLFAX	10,441	3,017	748	186	1,085	455	26	74	14	16	21	66	56	778	528
CUMING	10,203	2,774	665	138	261	344	34	66	10	14	24	74	15	518	188
CUSTER	11,793	3,097	672	116	104	422	36	64	16	20	26	75	35	1,037	248
DAKOTA	20,253	6,177	1,772	402	2,473	1,409	67	33	15	17	23	73	140	2,206	1,148
DAWES	9,060	1,918	451	103	260	401	47	53	14	31	32	69	66	849	238
DAWSON	24,365	7,120	2,043	478	2,678	1,311	48	52	14	16	21	65	142	2,697	1,259
DEUEL	2,098	489	91	15	29	77	42	58	12	13	29	87	7	127	23
DIXON	6,339	1,741	405	62	167	260	46	54	12	17	12	78	17	313	149
DODGE	36,160	8,922	2,225	499	772	1,816	53	47	10	14	22	73	187	2,768	1,083
DOUGLAS	463,585	123,221	34,293	8,343	36,781	30,153	77	23	13	14	31	70	6,056	43,596	10,915
DUNDY	2,292	534	122	18	39	51	24	76	16	16	31	84	3	164	43
FILLMORE	6,634	1,748	387	52	108	231	56	44	8	11	21	76	10	475	137
FRANKLIN	3,574	875	186	31	17	144	41	59	17	15	43	74	12	237	58
FRONTIER	3,099	806	170	25	13	119	30	70	10	10	10	75	2	155	52
FURNAS	5,324	1,285	300	49	55	220	45	55	15	17	44	76	10	417	141
GAGE	22,993	5,514	1,353	265	259	970	53	47	10	13	25	83	98	1,557	393
GARDEN	2,292	499	83	18	21	86	26	74	22	22	52	79	6	171	19
GARFIELD	1,902	447	91	19	19	51	8	92	12	11	0	84	4	178	59
GOSPER	2,143	510	111	23	17	53	22	78	11	6	0	78	3	107	47
GRANT	747	218	37	4	7	34	50	50	17	21	0	65	1	57	11
GREELEY	2,714	731	154	28	31	89	46	54	22	23	0	74	8	204	75
HALL	53,534	14,535	4,090	884	3,475	2,996	59	41	16	20	28	73	557	6,177	2,349
HAMILTON	9,403	2,733	629	103	96	377	51	49	10	10	37	78	28	559	177
HARLAN	3,786	916	183	36	22	134	17	83	14	20	4	69	10	242	53
HAYES	1,068	284	47	9	19	7	3	97	26	26	46	70	0	47	4
HITCHCOCK	3,111	740	135	36	36	120	33	67	23	26	37	66	3	288	82
HOLT	11,551	3,148	674	126	78	371	14	86	15	13	22	81	31	951	293
HOOKER	783	188	32	9	7	19	30	70	5	6	0	74	1	50	21
HOWARD	6,567	1,860	397	77	60	300	35	65	14	13	24	77	31	488	114
JEFFERSON	8,333	1,940	440	91	62	297	51	49	10	15	8	75	36	535	122
JOHNSON	4,488	1,086	245	54	134	155	40	60	10	10	2	79	17	413	111
KEARNEY	6,882	1,842	424	77	96	283	56	44	13	20	25	76	33	571	155
KEITH	8,875	2,243	508	88	193	400	40	60	34	46	0	60	1	63	13
KEYA PAHA	983	234	60	15	17	27	12	88	12	13	22	80	14	360	64
KIMBALL	4,089	1,010	220	35	75	166	29	71	30	23	36	83	58	865	123
KNOX	9,374	2,393	539	98	373	374	27	73	10	12	24	75	1,476	17,129	5,547
LANCASTER	250,291	58,828	16,680	4,126	9,808	12,457	67	33	12	16	21	69	232	2,852	901
LINCOLN	34,632	9,085	2,287	483	1,051	1,812	64	36	13	18	11	33	4	44	12
LOGAN	774	211	40	9	10	27	32	68	23	23	9	68	17	49	8
LOUP	712	190	45	2	8	13	5	95	13	17	31	76	193	3,265	1,015
MADISON	35,226	9,450	2,433	5	1,732	1,748	55	45	22	11	100	73	0	30	10
MCPHERSON	533	147	39	604	10	9	19	81	10	10	25	76	28	544	185
MERRICK	8,204	2,260	522	83	102	355	61	39	20	24	36	72	32	568	115
MORRILL	5,440	1,480	321	48	266	226	27	73	17	24	23	74	9	290	78
NANCE	4,038	1,126	250	51	39	169	30	70	13	20	0	66	32	463	82
NEMAHA	7,576	1,756	352	90	81	324	35	65	17	17	38	78	17	339	95
NUCKOLLS	5,057	1,184	250	56	32	162	33	67	9	14	28	74	59	830	198
OTOE	15,396	4,050	986	172	245	638	53	67	14	14	0	80	6	176	51
PAWNEE	3,087	700	151	28	25	103	37	63	20	25	17	55	7	154	69
PERKINS	3,200	852	173	42	61	110	24	76	12	12	34	72	46	653	166
PHELPS	9,747	2,584	606	115	162	390	43	57	14	18	28	79	14	480	113
PIERCE	7,857	2,276	470	90	69	267	30	70	9	11	20	75	140	2,135	742
PLATTE	31,662	9,184	2,296	482	1,092	1,464	43	57	7	11	48	71	11	275	86
POLK	5,639	1,418	326	60	43	155	42	58	11	14	17	83	19	862	278
RED WILLOW	11,448	2,847	712	145	184	516	65	35	10	15	29	74	44	717	163
RICHARDSON	9,531	2,434	495	100	200	503	60	40	36	36	63	70	2	142	45
ROCK	1,756	404	96	15	7	52	22	78	9	7	21	70	23	822	371
SALINE	13,843	3,481	863	197	502	679	51	49	5	6	8	70	449	4,982	1,784
SARPY	122,595	37,367	10,112	2,376	6,047	6,135	60	40	7	10	8	73	50	1,030	294
SAUNDERS	19,830	5,532	1,260	235	179	735	46	54	22	26	42	72	346	4,557	1,170
SCOTTS BLUFF	36,951	9,588	2,404	538	2,953	2,387	58	42	6	8	9	79	20	649	214
SEWARD	16,496	4,079	942	203	173	536	43	57	20	27	42	75	47	648	184
SHERIDAN	6,198	1,587	359	72	340	337	48	51	19	33	0	61	6	245	82
SHERMAN	3,318	814	172	35	25	107	27	73	24	12	0	73	1	68	14
SIOUX	1,475	359	79	11	15	45	26	74	7	5	25	77	10	354	68
STANTON	6,455	1,922	433	85	130	273	68	32	15	16	51	81	12	332	54
THAYER	6,055	1,459	343	47	60	250	55	45	21	10	0	69	4	46	13
THOMAS	729	172	43	7	1	23	14	86	28	32	100	76	0	66	11
THURSTON	7,171	2,642	688	149	1,857	811	61	64	10	13	55	80	31	963	277
VALLEY	4,647	1,147	258	43	63	167	47	53	16	17	58	76	16	358	97
WASHINGTON	18,780	5,086	1,207	231	164	672	46	54	8	12	13	73	50	680	229
WAYNE	9,851	2,131	523	91	119	298	48	52	11	16	40	79	34	450	116
WEBSTER	4,061	957	210	31	32	150	30	70	14	12	27	68	10	224	47
WHEELER	886	258	69	6	5	23	19	81	28	32	100	76	0	66	11
YORK	14,598	3,691	814	170	181	539	41	59	10	13	55	80	31	963	277
STATE TOTAL	1,711,263	450,242	117,048	26,324	82,116	88,431	60	40	12	14	27	73			38,989

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	16. FREE/SUBSIDIZED BREAKFAST	17. FREE/SUBSIDIZED SCHOOL LUNCH	18. SUMMER FOOD PROGRAM	19. TEEN BIRTHS 10-17 1995-2004	20. OUT OF WEDLOCK BIRTHS 1995-2004	21. INFANT DEATHS 1994-2003	22. 1-19 DEATHS 1994-2003	23. LOW BIRTH WEIGHT 2004	24. GRADUATES 2003-2004	25. DROPOUTS 2003-2004	26. SPECIAL EDUCATION 2003-2004	27. COST PER PUPIL 2003-2004	28. HEAD START 2004	29. FOSTER CARE 12/31/04	30. STDs 19 & UNDER 1995-2004	31. JUVENILE ARRESTS 2004
ADAMS	339	1,395	183	130	1,125	30	30	26	378	41	938	10,856	162	131	254	250
ANTELOPE	75	616		15	135	2	6	5	130	5	184	8,448	17	13	15	4
ARTHUR	0	0		1	6	0	0	0	4	0	15	14,428		1		0
BANNER	0	42		1	9	1	2	0	15	1	11	12,434		0		0
BLAINE	0	76		17	2	0	1	0	14	0	24	11,572		0	1	0
BOONE	213	382		53	124	5	6	4	97	2	163	8,781	18	7	17	2
BOX BUTTE	27	565	65	53	474	9	9	13	169	2	364	8,794	56	13	39	213
BOYD	78	281		5	24	3	6	3	63	0	78	12,140		2	2	7
BROWN	33	139		11	56	2	4	4	46	1	89	8,997	18	0	13	7
BUFFALO	696	1,687	492	124	1,403	35	40	36	543	22	1,106	8,889	116	75	372	404
BURT	84	352		26	189	2	9	8	106	5	253	7,807	17	18	14	39
BUTLER	82	398		20	195	3	5	5	129	7	204	14,443	17	27	12	14
CASS	319	786		85	748	26	27	23	249	4	736	7,462	140	67	111	10
CEDAR	141	659		12	152	10	21	4	182	2	227	8,613	17	16	5	3
CHASE	0	254		19	99	4	6	1	87	2	106	13,140	10	6	4	20
CHERRY	106	287		19	192	5	7	3	78	3	129	13,350	20	16	1	3
CHEYENNE	205	503	245	47	325	11	12	10	144	4	262	9,464	40	37	18	109
CLAY	73	291	85	22	166	6	11	3	92	5	206	8,707	36	18	15	2
COLFAX	0	684		82	610	17	18	8	151	21	253	7,655	47	25	32	34
CUMING	79	666		37	273	5	8	5	170	12	275	9,191	36	4	10	36
CUSTER	98	680		37	255	8	9	6	158	11	310	8,872	20	31	22	73
DAKOTA	476	1,390	290	168	1,394	31	18	29	224	385	633	7,377	132	51	213	301
DAWES	128	328		24	260	4	5	7	171	47	245	8,305	48	10	140	49
DAWSON	417	1,964	741	207	1,461	38	46	36	313	60	835	10,993	61	112	111	235
DEUEL	0	171		8	44	1	6	2	36	2	64	10,722	15	4	1	3
DIXON	46	206		25	175	4	7	4	66	7	170	8,160	4	9	15	21
DODGE	341	1,671	157	129	1,289	31	39	36	484	45	1,162	8,811	125	185	199	238
DOUGLAS	13,317	26,448	1,779	2,867	23,897	574	457	654	5,539	1,054	12,908	7,857	1,088	2,218	11,446	3,801
DUNDY	31	105		4	33	0	5	0	25	0	55	10,420	10	1	1	4
FILLMORE	139	390		18	127	4	11	5	110	4	258	12,313	17	27	98	13
FRANKLIN	0	118		7	56	0	2	1	23	3	47	8,711	32	6	3	5
FRONTIER	40	265		8	49	1	7	3	68	0	116	10,158	10	6	7	10
FURNAS	193	528		12	87	7	6	2	119	1	220	8,967	20	9	8	32
GAGE	213	851		74	636	23	33	18	257	26	643	8,299	71	35	85	236
GARDEN	36	99		3	25	2	3	1	36	2	36	12,885	7	6	5	3
GARFIELD	27	109		3	23	2	1	0	30	0	55	9,103	17	1	1	0
GOSPER	36	90		9	53	3	1	2	25	0	69	7,927	10	10	4	11
GRANT	0	33		1	4	1	4	1	19	0	15	12,339		0		9
GREELEY	115	353		8	55	2	3	0	72	1	91	10,477	17	7	2	0
HALL	1,170	3,389	600	418	3,076	75	62	52	696	153	1,552	6,512	185	189	423	486
HAMILTON	0	403		24	165	8	4	14	153	1	299	9,184	18	17	28	44
HARLAN	22	86		5	67	2	5	3	30	0	57	8,042	10	3	4	12
HAYES	0	76		3	10	0	2	0	13	0	20	11,429		0	2	0
HITCHCOCK	58	148		8	65	1	2	2	32	0	56	11,598	10	6	1	3
HOLT	137	684	107	39	244	9	18	9	188	5	304	11,589	37	32	21	80
HOOKER	24	126		2	12	0	0	1	17	0	22	11,723		0		1
HOWARD	152	388		19	164	6	6	7	127	5	235	9,049	24	14	19	17
JEFFERSON	245	515	68	36	178	5	5	12	140	5	333	8,408	17	15	29	23
JOHNSON	61	268		14	108	2	7	0	63	7	132	8,554		15	17	19
KEARNEY	51	215		16	128	8	12	7	125	3	299	8,578	17	10	17	22
KEITH	55	328		45	245	10	8	9	116	14	206	8,854	17	15	28	57
KEYA PAHA	0	78		2	12	0	1	2	9	2	10	13,479		0		0
KIMBALL	70	153		15	118	2	4	6	49	15	87	9,964	20	25	17	3
KNOX	118	609	38	31	307	4	15	9	131	10	240	10,924	52	3	16	3
LANCASTER	2,793	7,889	1,105	1,021	8,998	233	168	301	2,581	525	6,402	7,845	980	936	3,535	2,864
LINCOLN	455	1,397	283	155	1,353	38	40	31	437	46	1,110	8,114	70	210	131	608
LOGAN	18	40		1	11	2	3	0	12	0	26	11,305		0	1	0
LOUP	34	89		1	6	0	1	0	13	0	18	10,045		1		0
MADISON	26	1,962	121	1	5	36	47	0	563	41	1,081	7,244	98	148	271	0
MCPHERSON				203	1,706	0	1	28	11	0	10	11,773		0		719
MERRICK	103	400		17	203	7	11	2	114	3	193	8,198	16	16	20	5
MORRILL	165	456	88	28	166	6	15	6	77	1	132	19,240	20	16	29	32
NANCE	50	267		21	104	4	6	7	69	3	93	8,860	17	7	12	0
NEMAHA	0	271		18	176	6	10	2	81	2	141	11,466	32	6	21	56
NUCKOLLS	30	397		18	103	2	7	5	107	2	309	9,905	35	10	13	6
OTOE	107	523		65	466	16	21	19	207	13	462	8,496	55	19	44	96
PAWNEE	99	208		5	39	3	5	3	36	1	91	8,829	17	2	7	10
PERKINS	0	119		6	45	1	4	0	54	2	77	10,738	10	3	1	7
PHELPS	69	348		36	232	6	12	5	144	11	337	9,789	17	21	15	45
PIERCE	120	392		19	169	8	12	4	123	4	246	7,741	4	13	17	19
PLATTE	244	1,435		151	1,160	35	39	27	469	54	788	8,598	94	67	104	328
POLK	87	385		8	98	1	8	6	118	2	173	9,187		9	12	6
RED WILLOW	107	555		44	364	9	9	8	144	3	424	8,400	18	35	51	207
RICHARDSON	245	707		33	251	6	9	9	160	13	251	8,709	52	9	21	64
ROCK	0	64		6	18	1	2	0	29	0	42	11,136		1	1	4
SALINE	182	623		42	421	8	13	9	182	10	415	7,412	32	34	83	97
SARPY	358	2,820		379	3,572	122	99	163	1,512	61	2,805	7,482	125	290	819	1,453
SAUNDERS	98	728		41	399	12	14	15	265	7	510	8,986	88	44	55	88
SCOTTS BLUFF	493	2,079	531	321	1,953	35	51	49	388	61	751	7,433	334	187	407	525
SEWARD	52	501		28	272	5	14	12	219	10	396	10,231	17	37	39	80
SHERIDAN	77	352		29	238	5	9	5	70	13	124	12,870	40	15	21	74
SHERMAN	57	199		13	86	4	6	1	42	3	77	9,006	18	5	6	1
SIOUX	0	0		1	12	2	0	0	12	0	9	19,445		0	1	0
STANTON	53	144		22	153	0	7	4	40	0	80	5,989	17	8	10	49
THAYER	48	263		10	85	3	10	6	77	0	146	11,126	17	6	12	19
THOMAS	0	56		2	9	1	3	0	18	0	14	11,185		0		0
THURSTON	299	918	344	129	1,031	19	12	3	97	58	410	10,342	208	2	286	2
VALLEY	38	268		10	86	4	5	3	67	2	106	8,838	20	14	12	10
WASHINGTON	44	465		38	394	16	21	10	265	9	549	7,410	18	23	79	128
WAYNE	69	397		15	216	7	13	5	130	3	256	7,784	17	5	57	42
WEBSTER	53	200		10	75	3	3	0	56	0	148	9,203	37	2	5	18
WHEELER	48	77		1	16	2	1	0	9	0	15	11,468		0		0
YORK	94	580		29	423	12	11	13	203	6	391	9,499	47	57	35	157
STATE TOTALS	27,144	81,902	7,322	7,992	66,243	1,724	1,764	1,862	21,712	2,630	47,015	7,798	5,448	5,806	20,180	14,790

Methodology, Data Sources & Definitions

GENERAL

Data Sources: Sources for all data are listed below by topic. In general, data was obtained from the state agency with primary responsibility and from reports of the U.S. Bureau of Census and the U.S. Department of Commerce. With respect to population data, the report utilizes data from the 2000 U.S. Census of Population and Housing.

Race – *Race/Hispanic identification* – Throughout this report, race is reported based on definitions used by the U.S. Bureau of Census. The census requests adult household members to specify the race for each household member including children. New 2000 guidelines, implemented in an effort to reflect the growing diversity of our Nation's population, allowed the respondents to report as many racial categories as applied. Because the 1990 census required respondents to pick only a single, mutually exclusive, category, the 1990 and 2000 census data regarding race is not directly comparable. The 2000 census treats Hispanic origin as a separate category and Hispanics may be of any race, as did the 1990 census.

Rate – Where appropriate, rates are reported for various indicators. A rate is the measure of the likelihood of an event/case found in each 1,000 or 100,000 "eligible" persons. (Child poverty rates reflect the number of children living below the poverty line as a percentage of the total child population.)

Selected Indicators for the 2003 Report – The indicators of child well-being selected for presentation in this report reflect the availability of state data, the opinion and expertise of the *Kids Count in Nebraska* project consultants and advisors, and the national Kids Count indicators.

INDICATORS OF CHILD WELL-BEING

CHILD ABUSE AND NEGLECT/DOMESTIC VIOLENCE

Data Sources: Data was provided by the Nebraska Health and Human Services System, (HHSS), and the Nebraska Domestic Violence/Sexual Assault Coalition. Data regarding hospital discharges and abuse fatalities was taken from Vital Statistics provided by HHSS.

Neglect – Can include emotional, medical, physical neglect, or failure to thrive.

Substantiated Case – A case has been reviewed and an official office or court has determined that credible evidence of child abuse and or neglect exists. Cases are reviewed by HHSS and/or an appropriate court of law.

Agency Substantiated Case – HHSS determines a case to be substantiated when they find indication, by a "preponderance of the evidence" that abuse and/or neglect occurred. This evidence standard means that the event is more likely to have occurred than not occurred.

Court Substantiated Case – A court of competent jurisdiction finds, through an adjudicatory hearing, that child maltreatment occurred. The order of the court must be included in the case record.

Domestic Violence Shelter – Shelters (public or private) for women and children whose health/safety are threatened by domestic violence.

EARLY CARE AND EDUCATION

Data sources: Parents in the Workforce data was taken from the U.S. Census of Population and Housing, 2000. Data concerning child care subsidies and licensed childcare was provided by HHSS. Data concerning Head Start was provided by the Administration for Children and Families, U.S. Department of Health and Human Services, Office of Family Supportive Services, Head Start and Youth Branch. Data concerning early childhood initiatives was obtained from the Nebraska Department of Education web site for Early Childhood.

Child Care Subsidy – HHSS provides full and partial child care subsidies utilizing federal and state dollars. Eligible families include those on Aid to Families with Dependent Children and families at or below 185% of poverty. As of July 1, 2002 the eligibility level was reduced to at or below 120% poverty for families not receiving ADC. Most subsidies are paid directly to a child care provider, while some are provided to families as vouchers.

Licensed Child Care – State statute requires HHSS to license all child care providers who care for four or more children for more than one family on a regular basis, for compensation. A license may be provisional, probationary or operating. A provisional license is issued to all applicants for the first year of operation.

Center Based Care – Child care centers which provide care to many children from a number of families. State license is required.

Family Child Care Home I – Provider of child care in a home to between 4 and 8 children from families other than providers at any one time. State license is required. This licensure procedure begins with a self-certification process.

Family Child Care Home II – Provider of child care serving 12 or fewer children at any one time. State license is required.

Head Start – The Head Start program includes health, nutrition, social services, parent involvement, and transportation services. This report focuses on the largest set of services provided by Head Start – early childhood education.

ECONOMIC WELL-BEING

Data Sources: Data related to Temporary Assistance to Needy Families, Kids Connection income guidelines, poverty guidelines, and child support collections was provided by HHSS. Data concerning divorce and involved children was taken from Vital Statistics provided by HHSS. Data enumerating the number of children in low-income families and cost burden for housing was taken from the 2000 Census of Population and Housing. Data on the Earned Income Tax Credit program was provided by the Department of Revenue.

EDUCATION

Data Sources: Data on high school completion, high school graduates, secondary school dropouts, expulsions, and children with identified disabilities was provided by the Nebraska Department of Education.

Dropouts – A dropout is an individual who: 1) was enrolled in school at some time during the previous year and was not enrolled at the beginning of the current school year, or 2) has not graduated from high school or completed a state or district-approved educational program. A dropout is not an individual who: 1) transferred to another public school district, private school, home school (Rule 12 or Rule 13), state or district-approved education program, or 2) temporary absence due to suspension, expulsion, or verified legitimate approved illness, or 3) death.

Graduation – As of 2002-2003 school year, Nebraska has adopted the National definitions for graduation rate. The definition was developed by the National Center for Education Statistics (NCES). For the past several years, Nebraska has published a twelfth grade graduation rate which simply compares high school diploma recipients to fall twelfth grade membership for the same year. The NCES definition attempts to calculate a four-year rate. These are two totally different approaches; one is a one-year retention rate, while the other is a four-year retention rate. For most districts, and for Nebraska as a whole, the graduation rate will decline under the new definition; however for a few districts the graduation rate will increase.

The rate incorporates four years worth of data and thus is an estimated cohort rate. It is calculated by dividing the number of high school completers by the sum of the dropouts for grades nine through twelve respectively, in consecutive years, plus the number of completers.

Expulsion – Exclusion from attendance in all schools within the system in accordance with section 79-283. Expulsion is generally for one semester unless the misconduct involved a weapon or intentional personal injury, for which it may be for two semesters (79-263).

Special Education – Specially designed instruction to meet the individual needs of children who meet the criteria of a child with an educational disability provided at no extra cost to the parent. This may include classroom support, home instruction, instruction in hospitals and institutions, speech therapy, occupational therapy, physical therapy, and psychological services.

HEALTH -PHYSICAL AND BEHAVIORAL

Data Sources: Data for Medicaid participants was provided by HHSS. Data related to pertussis, immunizations, STD's, and blood lead levels was provided by the HHSS. Data related to infant mortality, child mortality, and birth is based on HHSS 2001 Vital Statistics Report. Data related to adolescent risk behaviors sexual behaviors, and use of alcohol, tobacco, and other drugs are taken from the 2001 Youth Risk Behavior Survey. Data enumerating motor vehicle accident related deaths and injuries was provided by the Nebraska Department of Roads.

Data pertaining to children receiving mental health and substance abuse treatment in public community and residential treatment facilities was provided by HHSS.

Prenatal Care – Data on prenatal care is reported by the mother and on birth certificates.

Low Birth Weight – A child weighing less than 2,500 grams or approximately 5.5 pounds at birth.

JUVENILE JUSTICE

Data Sources: Data concerning total arrests and the number of juveniles in detention centers was provided by the Nebraska Commission of Law Enforcement and Criminal Justice. Data concerning juveniles currently confined or on parole was provided by the HHS, Office of Juvenile Services. Data on youth committed to YRTC programs was provided by HHS. Data on youth in the adult corrections system was provided by the Department of Corrections. Data on youth arrested/convicted of serious crimes and juvenile victims of sexual assault was provided by the Crime Commission. Data concerning juveniles on probation was provided by the Administrative Office of the Courts and Probation.

Juvenile Detention – Juvenile detention is the temporary and safe custody of juveniles who are accused of conduct subject to the jurisdiction of the Court, requiring a restricted environment for their own or the community's protection, while pending legal action.

Youth Rehabilitation and Treatment Center (YRTC) – A long term staff secure facility designed to provide a safe and secure environment for Court adjudicated delinquent youth. A YRTC is designed to provide services and programming that will aid in the development of each youth with a goal of successfully reintegrating the youth back into the community.

NUTRITION

Data Sources: Data on households receiving food stamps, the USDA Special Commodity Distribution Program, the USDA Commodity Supplemental Foods Program, and the WIC Program was provided by HHSS. Data related to the USDA Food Programs for Children was provided by the Nebraska Department of Education.

OUT OF HOME CARE

Data Sources: Data were provided by HHSS and the Foster Care Review Board.

Approved Foster Care Homes – HHSS approves homes for one or more children from a single family. Approved homes are not reviewed for licensure. Data on approved homes had been maintained by HHSS since 1992. Often these homes are the homes of relatives.

Licensed Foster Care Homes – Must meet the requirements of the HHSS. Licenses are reviewed for renewal every two years.

Out-of-Home Care – 24 hour substitute care for children and youth. Out-of-home care is temporary care until the child/youth can be returned to his or her family, placed in an adoptive home, receives a legal guardian, or reaches the age of majority. Out-of-home care includes the care provided by relatives, foster homes, group homes, institutional settings, and independent living.

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